

**UNIVERSITY OF OKLAHOMA
NOTICE OF PRIVACY PRACTICES**

EFFECTIVE DATE: April 14, 2003

LAST REVISED: October 1, 2018

This NOTICE describes your rights regarding your medical information and informs you of how it may be used and disclosed. It applies to the health information that is protected by the Health Insurance Portability and Accountability Act (HIPAA), used to make decisions about your care, and generated or maintained by the University of Oklahoma (OU). Please review it carefully.

By law, OU must protect the privacy of your health information, give you this Notice of OU's legal duties and privacy practices, and follow the current Notice. It will be followed by all employees, students, and volunteers of the health care components of OU, which include, but are not limited to the parts of these areas covered by HIPAA:

College of Allied Health
College of Dentistry
College of Medicine and
OU Physicians
School of Community Medicine - Tulsa
and OU Physicians – Tulsa
College of Nursing
College of Pharmacy
College of Public Health
Department of Athletics
OU Health Services - Goddard
OUHSC Student Counseling Services
University Counseling Center -
Goddard
Certain administrative offices
Certain operations offices

1. Permitted Uses and Disclosures of Your Health Information

The following describe some of the ways that OU may use or disclose your health information without your authorization:

Treatment: To provide you with medical treatment/services and for treatment activities of other health care providers. *Examples:* Your health information may be used by doctors and students involved in your care. OU may use an electronic prescribing gateway with pharmacies.

Payment: For payment activities, such as to determine plan coverage or to bill/collect your account. *Example:* Your health information may be released to an insurance company to get pre-approval for services or to a collection agency if your account is not paid.

Operations: For uses necessary to run OU's healthcare businesses. *Example:* OU may use your health information to conduct internal audits to verify proper billing procedures.

Health Information Exchange: In a health information exchange (HIE), an organization in which providers

exchange patient information to facilitate health care, avoid duplication of services (such as tests) and reduce the likelihood of medical errors. By participating in an HIE, OU may share your health information with other providers who participate in the HIE or participants of other HIEs. If you do not want your medical information in the HIE, you must request a restriction using the process outlined in paragraph 6 below or by contacting the HIE.

Education: To faculty, staff, current and prospective students, volunteer and visiting faculty, and trainees and observers as part of its educational mission. Education is part of OU's healthcare operations and treatment programs. *Example:* Your provider may discuss your case with students as part of a learning experience.

Business Associates: To other entities that provide a service to OU or on OU's behalf that requires the release of your health information, such as a billing service, but only if OU has received satisfactory assurance that the other entity will protect your health information.

Individuals Involved in Your Care or Payment for Your Care: To a friend, family member, or legal guardian who is involved in your care or who helps pay for your care.

Research: To researchers for Research if the authorization requirement has been waived or revised by a committee charged with making sure the disclosure will not pose a great risk to your privacy or that steps are being taken to protect your health information, to researchers to prepare for research under certain conditions, and to researchers who have signed an agreement promising to protect the information.

Organ and Tissue Donation: To donation banks or organizations that handle organ or tissue procurement or transplantation, if you are an organ or tissue donor.

Fundraising: OU may use (or release to an OU-related foundation) your name, DOB, address, department of service, outcome, physician, insurance status, and treatment dates for fundraising. If you do not want to be contacted for fundraising efforts, notify OU's Privacy Official at the phone number or address in Paragraph 6 below. OU will not sell your health information without your written permission.

Marketing: To send you information regarding treatment alternatives or other health-related products or services. You may opt out of receiving these communications by notifying OU's Privacy Official at the phone number or address in paragraph 6 below.

2. Required Uses and Disclosures of Health Information: The following describe some of the ways that OU may be allowed or required by law to use or disclose your health information without your authorization:

Required by Law/Law Enforcement: If required by federal, state, or local law, such as for workers' compensation, and if requested by law enforcement officials for certain purposes such as to locate a suspect or in response to a court order.

Public Health and Safety: To prevent a serious threat to the health and safety of you, others, or the public and for public health activities. *Example:* Oklahoma law requires OU to report birth defects and cases of communicable disease.

Food & Drug Administration (FDA) and Health Oversight Agencies: To the FDA and manufacturers to enable product recalls, repairs, or replacements; and to health oversight agencies for activities authorized by law, such as audits or investigations.

Lawsuits/Disputes: If you are involved in a lawsuit/dispute and have not waived the physician-patient privilege, OU may disclose your health information under a court/administrative order or subpoena.

Coroners, Medical Examiners, and Funeral

Directors: To coroners, medical examiners, or funeral directors to enable them to carry out their duties.

National Security/Intelligence Activities

and Protective Services: To authorized national security agencies for the protection of certain persons or to conduct special investigations.

Military/Veterans: To military authorities if you are an armed forces or reserve member.

Inmates: If you are an inmate of a correctional facility or are in the custody of law enforcement, OU may release your health information to a correctional facility or law enforcement official so they may provide your health care or protect the health and safety of you or others.

Oklahoma law requires that OU inform you that health information used or disclosed may indicate the presence of a communicable or noncommunicable disease. It may also include information related to mental health.

If OU wants to use and/or disclose your health information for a purpose not in this Notice or not required or permitted by law, OU must get authorization from you for that use and/or disclosure, and you may revoke it at any time by contacting the Privacy Official at the phone number or address in Paragraph 6.

OU must obtain your authorization for most uses or disclosures of your psychotherapy notes and substance use disorder records. Some exceptions include use for Treatment by your provider or disclosures required by law.

3. Your Rights Regarding Your Health

Information: You have the following rights in regard to the health information that is protected by HIPAA that OU maintains about you. You must submit a written request to exercise any of these rights. Request forms are available at any of the locations where OU provides medical services. You also can get the forms by contacting the University's Privacy Official at the number or address in Paragraph 6 or at <https://apps.ouhsc.edu/hipaa/forms-patients.asp>.

Right to Inspect/Copy: To review and get a copy of your health information. This right does not apply to psychotherapy notes and certain other information. OU may charge for its costs for the copies and supplies, plus postage, payable prior to the release of the requested records. OU may deny your request in certain circumstances. You

may request a review of a denial based on medical reasons; OU will comply with this decision.

Right to Amend: If you believe health information OU created is inaccurate or incomplete, you may ask OU to amend it. You must provide a reason for your request. OU may deny your request if you ask to amend information that OU did not create (unless the creator is not available to make the amendment); that is not part of the health information OU maintains; that is not part of the information you are permitted by law to review and copy; or that is accurate and complete.

Right to Accounting of Disclosures: To ask for a list of disclosures OU has made of your health information. OU is not required to list all disclosures, such as those you authorized. *You must state a time period, which may not be longer than 6 years or include dates before April 14, 2003.* If you request more than one accounting in a 12-month period, OU may charge you for the cost. OU will tell you the cost; you may withdraw or change your request before the copy is made.

Right to Request Restrictions: To request a restriction or limit on how OU uses or discloses your health information. Your request must be specific. You may restrict disclosure of your health information to a health plan only if the disclosure is for payment or health care operations and pertains to a Health Care item or Service for which you pay out-of-pocket in full at the time it is provided. OU is not required to agree to other requests. If OU agrees or is required to comply, OU will comply with the request unless the information is required to be disclosed by law or is needed in case of emergency. *Example:* You may want to pay cash in advance for services rather than have your insurance billed.

Right to Request Confidential Contacts: To request that OU contact you in a certain way, such as by mail. You must specify in writing how or where you wish to be contacted; OU will try to accommodate reasonable requests.

Right to a Copy of This Notice: To receive a paper or electronic copy of this Notice, which is posted and available at each location where medical services are provided and is on OU's website.

Right to Designate a Representative: If you have given someone a medical power of attorney or have a legal guardian, that person can exercise your rights under HIPAA and make choices about

your health information. We may require proof of this person's status.

4. Changes to this Notice: OU reserves the right to change this Notice and to make the revised Notice effective for health information OU created or received about you prior to the revision, as well as to information it receives in the future. Revised Notices will be posted and available at each location where medical services are provided and on OU's website.

5. Right to be Notified. You have the right to be notified of breaches that may have compromised the privacy or security of your health information.

6. Information/Complaints. If you believe your privacy rights have been violated, you may file a complaint with OU's Privacy Official, Jill Bush Raines, at (405) 271-2511; 1-866-836-3150; OU.Compliance@ouhsc.edu; or PO Box 26901, OKC, OK 73126-0901; or with the Secretary of the Department of Health and Human Services, Office for Civil Rights – DHHS, 1301 Young Street, Suite 1169, Dallas, TX 75202, (800) 368-1019; (800) 537-7697 TDD; Email: ocrmail@hhs.gov.

Complaints must be submitted within 180 days of when you knew or should have known of the circumstance leading to the complaint. **You will not be retaliated against for filing a complaint.**

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html



OU Office of Compliance
P O Box 26901
Oklahoma City, OK 73126-0901
Phone (405) 271-2511
Fax (405) 271-1076

Anonymous OU Compliance Hotline –
405-271-2223 / 866-836-3150

Si necesita recibir este aviso en español,
favor de ponerse en contacto con la
Oficina de Cumplimiento anotada arriba.

The University of Oklahoma
OU Health Services
Goddard Health Center
620 Elm Avenue
Norman, OK 73019-3146

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided the University of Oklahoma's ("OU") Notice of Privacy Practices ("Notice").

- The Notice tells me how OU will use my health information for the purposes of my treatment, payment for my treatment and OU's health care operations.
- The Notice explains in more detail how OU may use and share my health information for purposes other than treatment, payment and health care operations.
- OU will also use and share my health information as required/permitted by law.
- If I am an OU student receiving student health services, I consent to OU using and disclosing my treatment and education records it maintains for the purposes detailed in OU's Notice of Privacy Practices.

Patient's COMPLETE Legal Name: _____
Please Print Legibly

Patient's Date of Birth: _____
Month Day Year

SIGNATURE

Of Patient: _____ Date: _____

SIGNATURE of Legally

Authorized Guardian

Or Representative if

Patient is a Minor*: _____ Date: _____

* May be requested to show proof of representative status.

The University of Oklahoma
OU Health Services
Goddard Health Center
620 Elm Avenue
Norman, OK 73019-3146

**CONSENT FOR USE OF PROTECTED HEALTH INFORMATION FOR
IN-OFFICE TREATMENT, PAYMENT AND OPERATIONS**

I consent to the use of my Protected Health Information for treatment, payment for treatment, and OU's health care operations purposes for myself or for the patient for whom I am the parent or legally authorized representative. I understand that the University of Oklahoma ("OU") will share patient protected health information according to the federal and state law for treatment, payment, and operations, as well as in accordance with its Notice of Privacy Practices.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. I agree that the patient must pay for services as the patient incurs the charges. I authorize OU to provide necessary information to the patient's insurance carrier or other payer for payment purposes, and I authorize my insurance company/payer to pay OU for services filed on my behalf. This assignment remains effective until I revoke it in writing.

If I am an OU student seeking student health services or treatment, I consent to the release of my treatment/education records for payment for services rendered to my insurance carrier or payer and authorize the carrier or payer to pay OU for services rendered.

Patient's COMPLETE Legal Name: _____
Please Print Legibly

Patient's Date of Birth _____
Month Day Year

SIGNATURE

Of Patient: _____ Date: _____

SIGNATURE of Legally
Authorized Guardian
or Representative if
Patient is a Minor*:

Date: _____
* May be requested to show proof of representative status.

OU Health Services

620 Elm Ave.
Norman, OK 73019
405-325-4611
fax: 405-325-7542

2020/21 Influenza Vaccine

(Please Print)

☐ OU Student

☐ Nonstudent (faculty, staff, dependent, retiree)

OU ID # _____

Last Name	First Name	Middle Initial	Maiden Name
()			
Date of Birth	Age	Sex	Phone Number
Street Address	City	State	Zip Code

- Yes No 1. Have you had a severe reaction to the influenza (flu) vaccine?
- Yes No 2. Are you allergic to eggs, chicken protein, neomycin, polymyxin or gelatin?
- Yes No 3. Do you have a history of Guillain-Barre Syndrome, a condition that causes paralysis?
- Yes No 4. Are you currently ill or do you have a fever?

Please describe any Yes answers: _____

I have read the CDC Influenza (08/15/19) Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that it be given to me or to the person named below for whom I am authorized to make this request.

Signature of person to receive vaccine or
signature of parent/guardian if person to receive vaccine is a minor.

Date

Nursing Personnel Use

Fluarix NDC: 58160-885-41
Exp. 6/30/2021 Lot# LP9HK

Date	Time	.50 cc	L R	Deltoid/IM	Flu Vaccine Lot #
		Amount	Site/Route		

☐ OUHS

☒ Outreach Location _____

Nurse Signature