



## **NOTICE OF PRIVACY PRACTICES**

Effective: April 14, 2003

Revision Date: August 1, 2013, June 6, 2019

### **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices (the “Notice”) describes the legal obligations of the Franciscan Missionaries of Our Lady Health System and its covered entity affiliates (the “Organization”) and your legal rights regarding protected health information held by the Organization under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). HIPAA protects only certain health information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to your past, present or future physical or mental health condition or the payment for health care services. This information can be transmitted or maintained in any form by the Organization.

#### **WHO WILL FOLLOW THIS NOTICE**

This Notice describes the Organization’s practices and that of:

- All employees, staff, volunteers, contractors and other personnel.
- All departments and units of the Organization.
- Any member of a volunteer group we allow to help you while you are in our care.
- Any physician or allied health professional who is a member of the Medical Staff and involved in your care.
- All entities, sites and locations will follow the terms of this Notice. When this Notice refers to “we” or “us”, it is referring to the following entities, sites and locations. In addition, these entities may share medical information with each other for treatment, payment or health care operations purposes described in this Notice.

The Organization, its’ Medical Staff, and other health care providers affiliated with the Organization participate in an Organized Health Care Arrangement (OHCA) under HIPAA for the purpose of sharing protected health information for treatment, payment, and health care operations. Participants include Our Lady of the Angels Hospital, Our Lady of the Lake Regional Medical Center, Our Lady of Lourdes Regional Medical Center, Heart Hospital of Lafayette, St. Francis Medical Center, St. Dominic Jackson Memorial Hospital, Senior Services, Health Centers in Schools, Affiliated Organization Physician Groups, Health Leaders Network Next Generation ACO, Community Connect and RX One. Please note that this list is not all inclusive.

In addition, the Organization utilizes a HIPAA compliant unified electronic medical record system to support efficient care, services and to promote healthcare continuity. Finally, designated facilities within the organization serve as teaching sites for LSU Health Sciences Center. LSU faculty are clinically integrated at sites of care for training and educational purposes.

#### **OUR PLEDGE REGARDING HEALTH INFORMATION:**

We understand that medical information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive at our Organization. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all the records of

Our Lady of the Angels | Our Lady of the Lake | Our Lady of Lourdes  
St. Francis Medical Center | St. Dominic Jackson Memorial Hospital

your care generated by our Organization, whether recorded in your medical record, invoices, payment forms, videotapes or other ways, that include protected health information. Physicians and other care providers who are not employed by the Organization may have different policies or notices regarding the use and disclosure of your protected health information created in the physician's office or clinic.

### **ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE**

You will be asked to provide a signed acknowledgement of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

### **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

In some circumstances we are permitted or required to use or disclose your protected health information without obtaining your prior authorization and without offering you the opportunity to object. The following categories describe these different circumstances. For each category of uses or disclosures we will explain what we mean and list an example. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use and disclose your protected health information to provide you with medical treatment or services. We may disclose your protected health information to doctors, nurses, technicians, medical students, or other health care providers who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as medications, lab work and x-rays and we may disclose your protected health information to third parties with whom we coordinate and manage your care.
- **For Payment.** We may use and disclose your protected health information so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may inform your health insurance company of your diagnosis and treatment in order to assist the insurer in processing our claim for the health care services provided to you or share information with a person who helps pay for your care.
- **For Health Care Operations.** We may use and disclose your protected health information for our day-to-day operations and functions. For example, we may we may compile your protected health information, along with that of other patients, in order to allow a team of our health care professionals to review that information and make suggestions concerning how to improve the quality of care provided at our Organization. We may also disclose information to doctors, nurses, technicians, medical students, members of our quality improvement team, and other participants in our organized health care arrangements for review and learning purposes and to improve the quality and effectiveness of the services you receive. The entities and individuals covered by this Notice may share information for their joint health care operations.
- **To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain and/or transmit

protected health information about you, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information.

- **Health Information Exchange.** We may share your information for treatment, payment, and healthcare operations purposes through a Health Information Exchange (HIE) in which we participate in order for participants to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. A HIE is a secure electronic system that helps health care providers and entities such as health plans and insurers managed care and treat patients. We will send your health information to the Epic Care Everywhere HIE, the Cerner CommonWell HIE and other HIEs as we choose to participate in them. Information about your past medical care and current medical conditions and medicines is available not only to us but also to non-Organization health care providers who participate in the HIE. You have the right to opt out of the HIE. However, even if you do, some of your health information will remain available to certain health care entities as permitted by law.
- **Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment or medical care at our Organization.
- **Treatment Alternatives.** We may contact you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may contact you about health-related benefits or services such as disease management programs and community-based activities in which we participate that may be of interest to you.
- **Fundraising Activities.** We may contact you as part of our effort to raise funds for our Organization. You have a right to opt out of receiving fundraising communications and all fundraising communications will include information about how you may opt out of future communications.
- **Research.** Under certain circumstances, we may use and disclose your protected health information for research purposes through a special approval process designed to protect patient safety, welfare, and confidentiality. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. We may also disclose your protected health information to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the information they review does not leave the hospital.
- **As Required By Law.** We will disclose your protected health information when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

### **SPECIAL SITUATIONS**

- **Organ and Tissue Donation.** If you are an organ donor, we may disclose your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose your protected health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may disclose your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose your protected health information for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report to state and federal tumor registries;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to provide proof of immunization to a school that is required by state or other law to have such proof with agreement to the disclosure by a parent or guardian of, or other person acting in loco parentis for an unemancipated minor;
  - to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Judicial and Administrative Proceedings.** We may disclose your protected health information in response to and in accordance with a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute after we have received assurances that efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may disclose your protected health information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
  - About a death we suspect may be the result of criminal conduct;
  - About criminal conduct at the Organization; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may disclose your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine cause of death. We may also release health information about patients of the Organization to funeral directors as necessary to carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official. This release would be permitted (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **National Security and Intelligence Activities.** We may release your protected health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

We may also use or disclose your protected health information in the following circumstances. However, except in emergency situations, we will inform you of our intended action prior to making any such uses and disclosures and will, at that time, offer you the opportunity to object.

- **Hospital Directory.** We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing.
- **Individuals Involved in Your Care or Payment for Your Care.** We may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the hospital. In addition, we may disclose your protected health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

With few exceptions, we must obtain your written authorization for uses and disclosures of your protected health information involving (1) certain marketing communications about a product or service and whether financial remuneration is involved, (2) a sale of protected health information resulting in remuneration not permitted under HIPAA; and (3) psychotherapy notes, except for certain treatment, payment and health care operations purposes, if the disclosure is required by law or for health oversight activities, or to avert a serious threat.

Except as permitted under HIPAA or as described above, disclosures of your protected health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless we have acted in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

## **YOUR RIGHTS:**

You have the following rights regarding health information we maintain about you:

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

Except as provided below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Effective September 23, 2013, we will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the Organization has been paid out-of-pocket in full. The Organization is not responsible for notifying subsequent healthcare providers of your request for restrictions on disclosures to health plans for those items and services, so you will need to notify other providers if you want them to abide by the same restriction.

To request restrictions, you must make your request in writing to the Privacy Officer of your facility as designated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer of your facility as designated below. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

- **Right to Inspect and Copy Health Information.** You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in anticipation of or for use in civil, criminal or administrative proceedings, or certain information that is governed by the Clinical Laboratory Improvement Act. If the requested protected health information is maintained electronically and you request an electronic copy, we will provide access in an electronic format you request, if readily producible, or if not, in a readable electronic form and format we mutually agree upon. We may charge a reasonable cost-based fee consistent with HIPAA and applicable state law.

Despite your general right to access your protected health information, access may be denied in limited circumstances. For example, access may be denied if you are an inmate at a correctional institution or if you are a participant in a research program that is still in progress. Access may be denied if the federal Privacy Act applies. Access to information that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonable be likely to reveal the source of the information. The decision to deny access under these circumstances is final and not subject to review. Otherwise, we will provide a written explanation on the basis for the denial and your review rights.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Medical Records Department of your facility as designated below. If you request a copy of the information, in accordance with applicable state law, you will be charged a fee for the costs of copying, mailing or other supplies associated with your request.

- **Right to Request Amendment.** If you feel that protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Organization. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the hospital;
  - Is not part of the information which you would be permitted to inspect and copy; or

- Is accurate and complete.

To request an amendment, your request must be made in writing and submitted to the Medical Records Department of your facility as designated below. In addition, you must provide a reason that supports your request. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting" of certain disclosures of your protected health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for: (i) disclosures made for the purpose of carrying out treatment, payment or health care operations unless HIPAA provides otherwise, (ii) disclosures made to you, (iii) disclosures of information maintained in our patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (iv) disclosures for national security or intelligence purposes, (v) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (vi) disclosures that occurred prior to April 14, 2003, (viii) disclosures made pursuant to an authorization signed by you, (viii) disclosures that are part of a limited data set, (ix) disclosures that are incidental to another permissible use or disclosure, or (x) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure for the period requested unless the period or right to receive the accounting is limited under HIPAA.

To request this list or accounting of disclosures, you must submit your request in writing to the Medical Records Department of your facility as designated below. Your request must state a time period. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we will charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

#### **Right to a Paper Copy of This Notice.**

You have the right to a paper copy of this Notice. You may obtain a copy of this Notice at the websites designated below. To obtain a paper copy of this Notice, contact the Compliance and Privacy Officer as designated below.

### **OUR DUTIES**

- We are required by law to make sure that health information that identifies you is kept private;
- We are required to provide you this Notice of our legal duties and privacy practices;
- We are required to notify you in the event that we discover a breach of unsecured protected health information, as that term is defined under federal law; and
- We are required to follow the terms of this Notice. We reserve the right to change the terms of this Notice and to make those changes applicable to all protected health information that we maintain. Any changes to this Notice will be posted on our website and at our facility and will be available from us upon request.

### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact the Patient Advocate as

designated below. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint.



Our Lady of the Angels  
433 Plaza Street, Bogalusa, LA 70427  
(985) 730-6800  
[www.oloah.org](http://www.oloah.org)

Our Lady of Lourdes Regional Medical Center  
4801 Ambassador Caffery Parkway, Lafayette, LA 70508  
(337) 470-2100  
[www.lourdesrhc.com](http://www.lourdesrhc.com)

Our Lady of the Lake Regional Medical Center  
5000 Hennessy Blvd, Baton Rouge, LA 70808  
(225) 765-4321  
[www.ololrhc.com](http://www.ololrhc.com)

St. Francis Medical Center  
309 Jackson St., Monroe, LA 71201  
(318) 966-4000  
[www.stfran.com](http://www.stfran.com)

St. Dominic Jackson Memorial Hospital  
969 Lakeland Drive  
Jackson, MS 39216  
(601) 200-2000  
[www.stdom.com](http://www.stdom.com)

## **CONTACT INFORMATION**

You may contact the appropriate Compliance and Privacy Officer below if you have questions about this notice.

Our Lady of the Angels  
(985) 730-2303

Senior Services  
(225) 765-5216

Our Lady of the Lake Regional Medical Center  
(225) 765-5216

St. Francis Medical Center  
(318) 966-4879

Our Lady of Lourdes Regional Medical Center  
(337) 470-2825

St. Dominic Jackson Memorial Hospital  
(601) 200-6302

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

I have received your Notice of Privacy Practices.

Printed Patient or Patient Representative Name: \_\_\_\_\_

Relationship to Patient (if signing for the patient): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

---

**FOR OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices acknowledgement, but was unable to do so as documented below:

REASON(S): \_\_\_\_\_  
\_\_\_\_\_

Employee Name and Date: \_\_\_\_\_