WHITESIDE COUNTY HEALTH DEPARTMENT & COMMUNITY HEALTH CLINIC
SUMMARY OF NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT

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.

YOUR RIGHTS	
You have the right to:	Get a copy of your health and claims record Correct your health &claims record Request confidential communication Ask us to limit the information we share Get a list of those with whom we've shared your information Get a copy of this privacy notice Choose someone to act for you as your personal representative File a complaint if you believe your privacy rights have been violated
YOUR CHOICES	
You have some choices in the way that we may share your information:	Disclosing information to your family and friends (requires written authorization) Tell family and friends about your condition Provide disaster relief Market our services and sell your information (requires written authorization) Raise funds
OUR USES AND DISCLOSURES	
We may use & share your information as we:	Treat you Run our organization Bill for your health services Help with public health and safety issues Do research Comply with the law, such as providing proof of immunity to a school Respond to organ & tissue donation requests and work with a medical examiner or funeral director Address workers' compensation, law enforcement, and other government requests Respond to lawsuits and legal actions Provide you with appointment reminders such as voicemail messages, postcards, texts or letters

We will never share any health information regarding Behavioral or Mental Health Services, Substance Abuse(drug/alcohol) Treatment, Physical Assault/Abuse/Neglect, and/or Sexually Transmitted Diseases including HIV/AIDS.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

I acknowledge that I have been given an opportunity to read this notice and receipt of the notice. I know that I may ask for a copy of the full notice. ***I authorize Whiteside County Health Department/CHC to release school physical records, dental records, to my child's School.***	Parent/Guardian Signature Date