sunrise
COMMUNITY HEALTH
affordable access, quality care, for all

NOTICE OF PRIVACY PRACTICES

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

Understanding Your Health Information

Each time you visit our community health center, a record of your visit is created. This record usually contains your name and other information that may identify you, your symptoms, examination and test results, diagnoses, treatment, plan for future health care, and financial information. This record is sometimes referred to as your "Medical record" or "medical chart." This record allows:

- Doctors, nurses, and other health professionals to plan your treatment;
- Our community health center to obtain payment for services we provide to you, such as from health plans, Medicaid, or you; and
- Our community health center to measure the quality of care provided to you.

As we have in the past, we are committed to keeping your health information confidential. We will not use or give to others your health information without your written permission, except as stated in this Notice.

How We Will Use and Give Out Your Health Information

a. Treatment, Payment, and Health Care Operations

We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our community health center. For example:

- We will give your health information to health care professionals outside of Sunrise Community Health, such as other doctors and hospital staff, who help care for you;
- We may send a bill to your health insurance plan or to you; and
- Our community health center may use your medical record to review our performance and make sure you receive quality health care.

Sunrise Community Health shares a common Electronic Health Record with clinical partners of the North Colorado Health Alliance. Clinical partners currently sharing the Electronic Health Record are Sunrise and the Weld County Department of Public Health and Environment. Each patient's chart is accessible to the appropriate staff at each facility to enable them to deliver comprehensive, quality health care.

b. Organized Health Care Arrangement

As permitted by law, Sunrise Health Clinics, Weld County Department of Public Health and Environment, School District 6 Greeley/Evans, Thompson School District, SummitStone Health Partners, Regional Accountable Entities (RAEs), Community Health Care Provider Alliance (CHPA), North Range Behavioral Health, and Community Pharmacies and/ or Pharmacy Benefit Managers have agreed to share your Health information among themselves for the purposes of treatment, payment, and healthcare operations. This enables us to better address your health care needs. This Notice serves as a single joint notice for all of these health care providers.

c. Other Uses and Disclosures Allowed or Required by Law

Sunrise Community Health endorses, supports, and participates in electronic Health Information Exchange (HIE) through Colorado Regional Health Information Organization (CORHIO) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time. If you choose to opt-out of this program, please be advised that losing the ability to share information with the hospitals and other providers may lead to additional cost to you by duplicating testing.

We may use or give out your health information for the following purposes under limited circumstances:

- To people who are involved in your care or who help pay for your care, such as your family, your close personal friends, or any other person chosen by you, to notify them of your location, general health, and to assist you in your health care (such as to pick-up medicine or help with follow-up care);
- To government agencies that oversee our community health center (such as license and certification inspectors);
- To government agencies that have the right to receive and collect health information (such as to control disease outbreaks);
- When we are ordered by a court or judge;
- To workers' compensation programs when your health problem is from a work-related injury;
- When law enforcement requests information (such as to prevent danger or injury);
- To coroners and funeral directors to allow them to carry out their duties;
- To organ donor agencies (subject to applicable laws);
- For research studies that meet all privacy law requirements (such as research to stop a disease);
- To avoid a serious threat to the health or safety of others;
- To contact you about new treatments or medicines that may help you;
- To business associates of the community health center that help us perform required tasks, such as our accountants, computer consultants, and billing companies (only if the business associate agrees in writing to keep your health information confidential as required by law); and
- For any other purpose required or allowed by law.

d. Other Uses and Disclosures Requiring Your Written Permission

- Except as stated above, we will use or give out your health information only after getting your written permission on an Authorization form. I understand that if I have authorized the release of drug abuse and/or alcohol abuse information that the confidentiality of this information is protected by Federal Law [42 CFR, Part 2]. This information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

Your Rights Regarding Your Health Information

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including the rights to:

- Request limits on uses of your health information
- Receive confidential communications of your health information
- Inspect and copy your health information
- Request a change to your health information
- Receive a record of how we have used and given out your health information
- Obtain a copy of this Notice of Privacy Practices

Questions, Concerns, and Changes to this Notice

If you have any questions or want to talk about any of the information in this Notice of Privacy Practices, please contact the Sunrise Compliance Hotline at 1.888.692.6675, Sunrise Community Health, 2930 11th Avenue, Evans, CO 80620.

If you believe your privacy rights have been violated, you may file a complaint with our community health center or with the Secretary of the Department of Health and Human Services. To file a complaint with our community health center, contact the Sunrise Compliance Hotline at 1.888.692.6675, Sunrise Community Health, 2930 11th Avenue, Evans, CO 80620. All complaints must be submitted in writing. We will not retaliate against you for filing a complaint.

We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by posting the changed notice at our community health center and on our web site.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge receiving and reading a complete copy of the Notice of Privacy Practices of
(Patient or Guardian)

Sunrise Community Health on this ____ day of _____, 20___. I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices.

X_____
Signature of Patient or Guardian

_____
Signature of Staff

_____
Printed Name of Patient or Guardian

_____
Printed Name of Staff

_____

_____
Address of Patient or Guardian

_____
Telephone Number of Patient or Guardian

Names of children in home	Date of Birth
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

☐ I **request** of copy of the privacy act for my review

☐ I **decline** a copy of the privacy act