

# Thomas Jefferson University

## Student Personal Counseling Center (SPCC)

### YOUR RIGHTS

#### 1. ELIGIBILITY

Counseling services are available to currently enrolled Jefferson students with a valid student ID as well as TJUH House Staff. A non-student may be permitted to be seen in the context of couples therapy with a Jefferson student or House Staff.

#### 2. SERVICES AVAILABLE

We offer a range of services, including individual, group, and couples counseling, psychiatric consultations, and wellness programs. You have the right to refuse diagnostic or treatment services. Your SPCC counselor may be a psychiatrist, psychologist, nurse practitioner or a psychiatry resident or psychology graduate student under the supervision of the professional staff. *Exception: JMC students will not be assigned to a psychiatric resident due to the potential for conflicts of interest inherent in their training.*

All Jefferson students with an active and valid student ID and TJUH House Staff are eligible for three visits without charge. These three visits renew each academic year, unless you have opted to receive ongoing care/treatment with an SPCC provider.

During the initial appointment, you will meet with a SPCC counselor and develop a course of action with your counselor, which may include continuing therapy on campus or receiving a referral to an off-campus provider. Some students may resolve their concerns during the initial three sessions and decide that no further sessions are required. Some students decide to see a SPCC counselor on an ongoing basis.

For students who opt to continue to receive ongoing services/treatment at the SPCC beyond the third visit, SPCC counselors are in-network with a limited number of insurance providers including the United HealthCare Student Resources Plan offered by Thomas Jefferson University (Students will be responsible for their copay each visit). For those without participating insurance, reduced fees and referrals to the community are available. Referrals may also be given in other circumstances, including but not limited to specialized services, treatments not available through the SPCC, or if the SPCC is functioning off a wait-list.

#### 3. PROMPT SERVICE

You will be seen for services in a timely manner. At busy times during the semester, Counseling Services may have a wait time or a wait list. If, however, you experience a crisis before your scheduled appointment, please contact us so that a crisis appointment can be arranged.

#### 4. RESPECT

SPCC staff will respect you as an individual and convey this respect by providing you with quality care and attention. SPCC counselors respect and support diversity and diverse populations.

### PRIVACY

#### 1. PRIVACY

SPCC counselors strive to uphold strict confidentiality and hold themselves to the highest level of clinical and ethical standards. Information shared by you will be kept in strict confidence. Because the SPCC operates as a team approach, SPCC staff may confer with each other as professionally necessary to provide the best possible service to you. It is important that you review Thomas Jefferson University's HIPAA Privacy Pamphlet that is included in your registration packet.

#### 2. LIMITS TO CONFIDENTIALITY

No one outside the SPCC may have access to the specifics of counseling sessions without the prior written permission of the student, except in situations where there is a threat or danger to life, including situations of child or elder abuse.

### YOUR RESPONSIBILITIES

#### 1. PARTICIPATION

Your active participation in the counseling process is necessary for progress to be made. It is important that you notify your counselor if your problem worsens.

#### 2. CANCELLATIONS

It is your responsibility to keep scheduled appointments. If you need to reschedule or cancel, please give us at least 24 hours' notice so that the time may be offered to another student in need. If you are persistently unable to keep your scheduled appointments, your counselor may discuss alternative treatment options with you. Please note that if you do not respond to a counselor's attempts to contact you or if you miss three consecutive scheduled appointments, we will assume you are no longer interested in counseling. You are welcome to contact the SPCC again in the future if the need arises.

#### 3. FEEDBACK

The SPCC staff is interested in any positive or negative feedback you may have regarding the services you receive. We may ask you to complete an anonymous evaluation asking you for feedback about our services. If for any reason you are not satisfied with the counseling process, we encourage you to discuss this first with your SPCC counselor. If your concerns are not resolved to your satisfaction, you may request an appointment with the SPCC Director to discuss possible reassignment or other counseling options.

### CONSENT TO TREATMENT

I hereby agree to counseling/treatment/assessment/consultation at the Student Personal Counseling Center. I have read the information contained above and understand these provisions and policies. I understand I may address any questions regarding this consent with a SPCC counselor. I also understand that this consent will remain in effect until I am no longer a Thomas Jefferson University student, and that I have the right to later revoke my consent. If I do not sign this consent, or later revoke it, the SPCC may decline to provide services to me.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature



Thomas  
Jefferson  
University

Jefferson  
University  
Physicians

Account No.	Entered Date
Reg. By	Office Site

# JUP Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.**

**Today's Date:** \_\_\_\_\_

Patient Name: _____ Last Name	Social Security Number: _____
First Name: _____ MI	Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Other Name: _____	Race: ( <b>Response is not mandatory. Data is used for statistical reporting.</b> )
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other	<input type="checkbox"/> African American <input type="checkbox"/> Asian/Oriental <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Addr1: _____	Home Phone: (_____) _____
Addr2: _____	Other Phone: (_____) _____
City, State, Zip: _____	
Home E-mail: _____	Home Fax: (_____) _____
Employer: _____	Emp Status: <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time
Addr1: _____	<input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker
Addr2: _____	<input type="checkbox"/> Student <input type="checkbox"/> Active Military <input type="checkbox"/> Self-Employed <input type="checkbox"/> Other _____
City, St, Zip: _____	Work Phone (_____) _____

**Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)**

Guarantor: _____	Patient's Relationship to Guarantor: _____
Addr1: _____	Social Security Number: _____
Addr2: _____	Date of Birth: _____
City, St, Zip: _____	Sex: _____
_____	Home Phone: (_____) _____
_____	Work Phone: (_____) _____
Employer: _____	
Addr1: _____	
Addr2: _____	
City, St, Zip: _____	

Emerg Cont: _____	Patient's Relationship to Emerg Cont: _____
Addr1: _____	Home Phone: (_____) _____
Addr2: _____	Work Phone: (_____) _____
City, St, Zip: _____	

How did you hear of our practice?  Billboard  Brochure  Health Fair  Health Plan  Internet  Jeff NOW®  Mass Mailing  
 Newspaper/Mag.  Ongoing Care  Other  Patient  Phone Bk  Phys. Off./ER  Relative  Radio  TV  Word of Mouth

### Insurance Information

**A separate form is required for workers' compensation, automobile liability, or legal services.**

PRIMARY CARRIER: _____	
Address: _____	Telephone #: (_____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____
SECONDARY CARRIER: _____	
Address: _____	Telephone #: (_____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____

### Primary Care Physician / Referring Physician

PCP: _____	Refer. Phys. (if different): _____
Addr: _____	Addr: _____
City, St, Zip: _____	City, St, Zip: _____
Telephone #: _____	Telephone #: _____



# JUP Patient Signature on File Form

## Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jefferson University Physicians and/or to the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

**In order to comply with Medicare regulations, please answer the following questions:**

- |   |   |
|---|---|
| Are you or your spouse employed?..... <input type="checkbox"/> Y <input type="checkbox"/> N                   | Has treatment been authorized by the V.A.? ..... <input type="checkbox"/> Y <input type="checkbox"/> N                      |
| Do you or your spouse have other insurance? ..... <input type="checkbox"/> Y <input type="checkbox"/> N       | Are you covered under the Black Lung Program? ..... <input type="checkbox"/> Y <input type="checkbox"/> N                   |
| Are you disabled or have end stage renal disease? .. <input type="checkbox"/> Y <input type="checkbox"/> N    | Is there Medigap coverage secondary to Medicare? .... <input type="checkbox"/> Y <input type="checkbox"/> N                 |
| Is illness/injury the result of an auto accident? ..... <input type="checkbox"/> Y <input type="checkbox"/> N | Is there insurance coverage primary to Medicare?..... <input type="checkbox"/> Y <input type="checkbox"/> N                 |
| Did illness/injury occur at work? ..... <input type="checkbox"/> Y <input type="checkbox"/> N                 | Is there employer supplemental coverage secondary.... <input type="checkbox"/> Y <input type="checkbox"/> N<br>to Medicare? |

## Medigap (Medicare Secondary Insurance)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Jefferson University Physicians for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to my Medigap Coverage any information needed to determine these benefits payable for related services.

## Pennsylvania Medical Assistance

I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

## Commercial

### Assignment of Insurance Benefits

I hereby authorize payment directly to Jefferson University Physicians for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this agreement, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

## General

### Release of Information

I hereby authorize Jefferson University Physicians to disclose to my insurance company(s) copies of my medical records(s) to obtain payment for services or as part of a post-payment review of medical services, or in the case of Workers Compensation claims, to my present or past employer(s). Additionally, I authorize Jefferson University Physicians to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that the information disclosed may be protected by federal and/or state law, and I specifically consent to disclose of such information. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it.

### Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for purposes of patient identification.

### Financial Agreement

In consideration of the services rendered to the below named patient, the undersigned agrees to pay Jefferson University Physicians in accordance with its regular charges and terms and, if this account is referred to an attorney or agency for collection, to pay attorney(s) fees, court costs, and collection expenses. I also agree to be responsible for charges not covered by insurance. I understand that my obligation to pay Jefferson University Physicians may not be deferred for any reason, including pending legal action against other parties, to recover medical costs.

**The undersigned certifies that each has read and understands the above terms and conditions.**

X \_\_\_\_\_  
Patient Signature Date

X \_\_\_\_\_  
Patient's Agent Representative and Guarantor Signature Date

**\*Please give your insurance card to the receptionist for copying.**

**Jefferson University Physicians**  
**Department of Psychiatry and Human Behavior Outpatient Services**  
**Health Questionnaire**

**Name:** \_\_\_\_\_

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

Please fill in this entire form. Do not leave any blank spaces. If a question does not apply to you please put N/A in the space. If you have any problems filling out this form please see the front desk staff. Your doctor will review this form with you after you have completed it.

1. Name and contact information for your primary physician:
  
2. When was your last physical examination? \_\_\_\_\_  
Overall finding of your last physical examination:
  
3. Current physical symptoms and concerns:
  
4. Current use of any medications (excluding psychotropic meds):
  
5. Are you allergic to anything?      \_\_\_\_\_ Yes      \_\_\_\_\_ No  
Drugs: \_\_\_\_\_  
Food: \_\_\_\_\_  
Environmental Agents: \_\_\_\_\_
  
6. History of hospitalizations and surgeries:
  
7. Has your weight changed in the past 3 months?      \_\_\_\_\_ Yes      \_\_\_\_\_ No  
Do you feel that you have a healthy diet?      \_\_\_\_\_ Yes      \_\_\_\_\_ No
  
8. Occupational or travel-related exposure to toxins, hazardous materials, etc.:
  
9. Do you have any laboratory tests currently pending? (If yes, please give details)
  
10. Family history of major medical illnesses (ex. Cardian condition, hypertension, etc.):

**REVIEWING PHYSICIAN SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**JEFFERSON UNIVERSITY PHYSICIANS  
GUIDELINES FOR EMAIL COMMUNICATIONS WITH JUP PATIENTS**

1. JUP shall be familiar with and comply with University Policy No. 115.11 entitled “*Email Encryption and Use of Email for Patient Communication*”.
2. JUP physicians, health care providers and other authorized JUP staff members may communicate with JUP patients via Email, but should not send or receive Email concerning JUP patients containing protected health information from any device except Jefferson managed or approved devices.
3. Email communications should not be used for time-sensitive, urgent or emergent patient issues. Email communications may be used to remind patients about appointments and for treatment-related communications between health care providers and patients after appointments. Safeguards should be applied to reasonably protect privacy, such as limiting the amount or type of information disclosed.
4. Before sending an Email communication to a JUP patient:
  - a. Confirm that the patient has provided permission or authorization to communicate via Email. The best practice includes making sure the patient prefers this form of communication and understands the risks associated with it. Patients should be made aware that providing permission to communicate via Email with JUP is providing permission for any and all JUP departments, practice sites and providers to communicate with the patient via Email. Patient permission or authorization may be documented as follows:
    - i. Before using Email to communicate with JUP patients, patients should be asked to complete the attached JUP Consent Form, “Patient Consent for Electronic Mail Use (Email)”. Completed forms should be scanned into the patient’s EMR.
    - ii. If patients who have not completed a JUP Consent Form for Email Use initiate communications with a JUP provider using Email, JUP providers can assume (unless the patient has explicitly stated otherwise) that Email communications are acceptable to the individual and may respond to the patients’ Email. The patients should be encouraged to sign a Consent Form for Email Use at their next scheduled appointment.
    - iii. If a JUP provider feels a patient may not be aware of the possible risks of using Email, or has concerns about potential liability, the provider should alert the patient about those risks, and let the patient decide whether to continue Email communications. These include, but are not limited to, the following risks:
      - a. Email can be circulated, forwarded, and stored in numerous paper and electronic files.
      - b. Email can be immediately broadcast worldwide and be received by many intended/unintended recipients.
      - c. Email senders can easily misaddress an email.
      - d. Email is easier to falsify than handwritten or signed documents.
      - e. Backup copies of Email may exist even after the sender or the recipient has deleted his or her copy.
      - f. Employers and on-line services have a right to archive/inspect Emails transmitted through their systems.
      - g. Email can be intercepted, altered, forwarded, or used without authorization or detection.
      - h. Email can be used to introduce viruses into computer systems.
      - i. Email can be used as evidence in court.
    - iv. If a patient has indicated he/she does not wish to communicate via Email, Email communication should not be used. Other means of communicating with the patient, such as by mail or telephone, should be offered and accommodated.
  - b. Take precautions when using Email to avoid unintentional disclosures, such as checking the Email address for accuracy or sending an Email alert to the patient for address confirmation before sending the message.
  - c. Ensure that the “Disclaimer and Caution” is on all outgoing patient Email communications.
5. After sending and/or receiving Email communications from JUP patients:
  - a. Print a copy of the Email communication in its entirety.
  - b. Ensure the Email communication is scanned into the patient’s EMR.

**JEFFERSON UNIVERSITY PHYSICIANS  
CONSENT FOR ELECTRONIC MAIL ("EMAIL") USE**

Jefferson University Physicians ("JUP") offers its patients the opportunity to communicate by Email for non-urgent matters. This form provides the guidelines and documents your consent for Email use.

**Email** Use of Email communications should be between JUP and an adult patient 18 years of age or older, or the parent or guardian of a minor.

**Do Not Use Email** **DO NOT USE EMAIL IN CASE OF A MEDICAL EMERGENCY OR URGENT OR TIME SENSITIVE MATTERS.** Do not use Email for communicating sensitive health care information such as sexually transmitted diseases, HIV, hepatitis, substance abuse, mental health or presence of malignancy. Do not send any attachments by Email. Do not use Email to request copies of medical records. Do not use an employer's computer to send Emails. Employers have a right to archive and inspect Emails transmitted through their systems. Do not use Email as a substitute for clinical evaluations and office appointments.

**Privacy, Security & Confidentiality** Although JUP has implemented reasonable technical safeguards, JUP cannot and does not guarantee the privacy, security or confidentiality of any Email messages sent or received over the Internet. There is a potential that Email sent or received over the Internet can be intercepted, altered, forwarded, and/or read by others. JUP is not responsible for Email messages that are lost due to technical failure during composition, transmission, or storage. JUP will not forward Emails to independent third parties without a patient's prior written consent, except as authorized or required by law. Patients must inform JUP of Email address changes. Patients should take precautions to preserve the confidentiality of Email, such as safeguarding computer passwords.

**Creating a Message** In the "Subject" line of the Email, patients should include the general topic of their message (i.e., medical advice). In the "Body" of the Email message, include the patient's name and date of birth. This information is necessary to verify your identity and make sure JUP can include the Email in the correct medical record.

**Email Message** Email communications should only be used for non-sensitive and non-urgent issues, such as general medical advice after an initial face-to-face visit

**Email Response** JUP cannot guarantee that you will receive a response to any particular Email. If you have not received a response within a reasonable time period, please call your JUP provider.

**Documentation** All Emails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those Emails.

**Email Use by JUP** You understand that if you give your Email address to JUP and sign this consent form, you are allowing JUP to use Email to communicate with you. JUP includes all of its departments, practice sites and providers.

**Ending Email** You may stop communicating by Email by sending an Email or letter to JUP.

**ACKNOWLEDGEMENT:** I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of Email as one form of communication with JUP.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Email Address

\_\_\_\_\_  
Date

## 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.

### **I. Who We Are**

This Notice describes the privacy practices of Thomas Jefferson University (TJU), Jefferson University Physicians (JUP), and TJUH System<sup>1</sup> and its controlled affiliates, including Thomas Jefferson University Hospitals, Inc. (TJUH, Inc.) (collectively referred to as Jefferson).

Jefferson facilities include all patient care, research, laboratory and administrative space owned or leased by Jefferson and any location where Jefferson employees work. All employees, medical staff, students and other members of the Jefferson community ("we" or "us") follow the terms of this Notice. Jefferson is required by law to maintain the privacy of your health information ("Protected Health Information" or PHI) and to provide you with this Notice.

### **II. How We May Use and Disclose Health Information – Treatment, Payment and Health Care Operations**

Except in an emergency or other special circumstance, we will ask you to sign a general authorization, as required by Pennsylvania law, so that we may use and disclose your PHI for the purposes detailed below:

#### **A. Treatment**

We may use and disclose your PHI in connection with your treatment and/or other services provided to you—for example, to diagnose and treat you. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. We may also disclose PHI to other providers (e.g. physicians, nurses, pharmacists and other health care facilities involved in your treatment).

#### **B. Payment**

We may use and disclose your PHI to obtain payment for services that we provide to you—for example, to request payment from your health insurer and to verify that your health insurer will pay for your health care services.

#### **C. Health Care Operations**

We may use and disclose your PHI for our health care operations. These include internal administration and planning, and various activities that improve the quality and cost effectiveness of health care services. For example, we may use your PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may also use PHI to resolve patient problems and complaints.

#### **D. Business Associates**

We may disclose your PHI to our business associates to perform certain business functions or provide us certain business services. A business associate is defined as a company which creates, maintains, receives or transmits PHI in its performance of services for us. For example, we may use another company to perform billing services on our behalf. Our business associates are required to maintain the privacy and confidentiality of your PHI.

#### **E. Other Health Care Providers**

We may also disclose PHI to other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, for example, for emergency ambulance companies to request payment for services in bringing you to the hospital.

### **III. Other Uses and Disclosures of Your PHI for which your written authorization is not required**

#### **A. Use or Disclosure for the In-Patient Directory**

If you are admitted to a Jefferson hospital facility, we may include your name, room number, general health condition and religious affiliation in our hospital patient directory without obtaining your written authorization, unless you choose to object after reading this Notice. Information in the hospital directory (other than religious affiliation) may be disclosed to anyone who asks for you by name, either in person or by telephone. This information, including your religious affiliation, may also be disclosed to members of the clergy.

#### **B. Disclosure to Relatives, Friends and Other Caregivers**

We may disclose your PHI to a family member, other relative, friend, or any other person if we:

1. obtain your agreement;
2. provide you with the opportunity to object to the disclosure and you do not object; or
3. we reasonably assume that you do not object.

If we provide information to any individual(s) listed above, we will release only information that we believe is directly relevant to that person's involvement with your health care or payment related to your health care. We may also disclose your PHI in the event of an emergency or to notify (or assist in notifying) such persons of your location, general condition or death.

#### **C. Fundraising Communications**

We may contact you to request a donation to support important activities of Jefferson. We may disclose to our fundraising staff certain demographic information about you (e.g. your name, address, other contact information, age, gender, and date of birth), dates on



which we provided health care to you, department of service information, your treating physician, outcome information, and your health insurance status. You may request to opt-out of receiving fundraising communications.

Jefferson will not condition treatment or billing for those services on your choice of whether to receive fundraising communications.

#### **D. Public Health Activities**

We may disclose your PHI for the following public health activities:

1. reporting births or deaths;
2. preventing or controlling disease, injury or disability;
3. reporting child abuse and neglect to public health or other government authorities authorized by law to receive such reports;
4. reporting information about products and services under the jurisdiction of the United States Food and Drug Administration, such as reactions to medications and problems with products;
5. alerting a person who may have been exposed to an infectious disease or may be at risk of contracting or spreading a disease or condition;
6. notifying people of recalls of products they may be using; and
7. reporting information to your employer as required by laws addressing work-related illnesses and injuries or workplace medical surveillance.

#### **E. Victims of Abuse, Neglect or Domestic Violence**

If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.

#### **F. Health Oversight Activities**

We may disclose your PHI to a health oversight agency that is responsible for ensuring compliance with rules of government health programs such as Medicare or Medicaid.

#### **G. Legal Proceedings and Law Enforcement**

We may disclose your PHI in response to a court order, subpoena or other lawful process.

#### **H. Deceased Persons**

We may disclose PHI of deceased individuals to a coroner, medical examiner or funeral director authorized by law to receive such information.

#### **I. Obtaining Organs and Tissues**

We may disclose your PHI to organizations that obtain organs or tissues for banking and / or transplantation.

#### **J. Research**

When conducting research, in most cases, we will ask for your written authorization before PHI is used. However, we may use or disclose your PHI without your specific authorization if Jefferson's Institutional Review Board ("IRB") has waived the authorization requirement. The IRB is a committee that oversees and approves research involving living humans.

#### **K. Public Safety**

We may use or disclose your PHI to prevent or lessen a serious and imminent threat to the safety of a person or the public.

#### **L. Specialized Government Functions**

We may release your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances, such as for intelligence, counter-intelligence or national security activities.

#### **M. Workers' Compensation**

We may disclose your PHI as authorized by state law relating to workers' compensation or other similar government programs.

#### **N. Inmates**

If you are or become an inmate of a correctional institution or you are in the custody of a law enforcement official, we may release your PHI to the institution or official if required to provide you with healthcare or to protect the health and safety of others.

#### **O. As required by law**

We may use and disclose your PHI when required to do so by any other laws not already referenced above.

### **IV. Uses and Disclosures Requiring Your Specific Written Authorization**

For any purpose other than the ones described above, we may use or disclose your PHI only when you give Jefferson your specific written authorization. For instance, you will need to sign an authorization form before we send your PHI to a life insurance company. The following are examples of other uses or disclosures for which your specific written authorization is required:

#### **A. Marketing**

Written authorization will be required prior to using or disclosing your PHI for marketing activities that are supported by payments from third parties.

However, authorization from you is not required if:

1. Jefferson receives no compensation for the communication;



2. the communication is face-to-face or consists of a promotional gift of nominal value provided by Jefferson;
3. the communication involves refill reminders of a drug or biologic the patient is currently being prescribed and the payment is limited to reasonable reimbursement of the costs of the communication (no profit);
4. the communication involves general health promotion and case management, rather than the promotion of a specific product or service; or
5. the communication involves government or government-sponsored programs.

## **B. Sale of PHI**

Should we wish to disclose your PHI in any manner that would constitute a sale of your PHI, we will obtain your written authorization to do so.

## **C. Highly Confidential Information**

Federal and state laws require special privacy protections for certain highly confidential information about you. This includes:

1. psychotherapy notes;
2. documentation of mental health and developmental disabilities services;
3. information about drug and alcohol abuse, prevention, treatment and referral;
4. information relating to HIV/AIDS testing, diagnosis or treatment and other sexually transmitted diseases; and
5. information involving genetic testing and other genetic-related information.

Generally, we must obtain your written authorization to release this type of information. However, there are limited circumstances under the law when this information may be released without your consent. For example, certain sexually transmitted diseases must be reported to the Department of Health.

## **V. Your Rights Regarding Your Protected Health Information**

### **A. Right to Inspect and Copy Your Health Information**

You may request to see and receive paper or electronic copies of your medical and billing records. To do so, please submit a written request to the appropriate Jefferson office or department. You will be charged for copies in accordance with established professional, Pennsylvania and federal guidelines and laws. If you are a parent or legal guardian of a minor, certain portions of the minor's medical record may be inaccessible to you under the law (for example, records relating to abortion, contraception and/or family planning services) unless the patient him/herself authorizes Jefferson to give you access to this PHI. Additionally, under limited circumstances defined by law, we may deny you access to a portion of your records.

### **B. Right to Request Restrictions**

You may request additional restrictions on Jefferson's use and disclosure of your PHI:

1. for treatment, payment and health care operations,
2. to individuals (such as family members, or other relatives, close friends or any other person identified by you) involved with your care or with payment related to your care,
3. to notify or assist in the notification of such individuals regarding your location in the hospital and your general condition, and
4. to your health plan (i.e. third party insurer or healthcare payor) when the PHI is the result of a healthcare item or service that has been fully paid out of pocket.

If we agree to a restriction, we will state the agreed restrictions in writing and will abide by them, except in emergency situations when the disclosure is needed for purposes of treatment.

### **C. Right to Receive Confidential Communications**

You may request, and we will accommodate, any reasonable written request from you to receive your PHI by alternative means of communication or at alternative locations. For example, you may instruct us not to contact you by telephone at home, or you may give us a mailing address other than your home for test results.

### **D. Right to Revoke Your Authorization**

You may revoke your authorization, except to the extent that we have already used or disclosed your PHI. A revocation form is available upon request from one of the Jefferson Privacy Officers, as noted below. This form must be completed by you and returned to the Privacy Officer.

### **E. Right to Amend Your Records**

You have the right to request that we amend PHI maintained in your medical or billing records. To do so, you must submit a written request to the appropriate Jefferson office or department. We may deny your request if Jefferson reasonably believes that the information is accurate and complete, if the PHI was not created by Jefferson, or other special circumstances apply.

### **F. Right to Receive An Accounting of Disclosures**

You may request a record of certain disclosures of your PHI. Your request may cover any disclosures made in the six years prior to the date of your request.

### **G. Right to Receive Notification**

You have the right to receive written notification from Jefferson in the event of a breach of unsecured PHI, i.e., if there is an unauthorized use or disclosure of your PHI which meets certain criteria under the law.

## **H. For Further Information; Complaints**

If you desire further information about your privacy rights, are concerned that your privacy rights were violated, or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officers at:

Privacy Officer  
Thomas Jefferson University  
Office of University Counsel  
1020 Walnut Street, 6th Floor  
Philadelphia, PA 19107  
(215) 955-8585

Privacy Officer  
Thomas Jefferson University Hospitals, Inc.  
Compliance Office  
925 Chestnut Street, Suite 311  
Philadelphia, PA 19107  
(215) 955-4177

Additionally, you may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. Filing a complaint will not result in retaliation.

## **VI. Effective Date and Duration of This Notice**

### **A. Effective Date**

This Notice is effective on April 14, 2003.

### **B. Date of Revision**

This Notice was revised, effective September 23, 2013

### **C. Right to Change Terms of this Notice**

We may change the terms of this Notice at any time. If we change this Notice, we will post the revised Notice in appropriate locations around Jefferson and online. You also may obtain any revised notice by contacting one of the Privacy Officers.

<sup>1</sup> TJUH System includes TJUH, Inc., (the Center City Campus, Methodist Hospital Division, Jefferson Hospital for Neuroscience), JeffCARE, Inc., Riverview Surgery Center at the Navy Yard, LLC, Riverview Surgery Center at the Navy Yard LP, Jeffex, Inc., Emergency Transport Associates Inc., Walnut Home Therapeutics, Inc., TJUH Health Affiliates, Jefferson medical Care, Methodist Associates in Health Care, Inc., The Atrium corporation, and Healthmark, Inc.

*Jefferson University Physicians  
Department of Psychiatry and Human Behavior*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND  
AUTHORIZATION TO RELEASE HEALTH INFORMATION**

By signing below, I acknowledge receipt of the Notice of Privacy Practices of Thomas Jefferson University ("TJU"), Thomas Jefferson University Hospitals, Inc. ("TJUH"), and Jefferson University Physicians ("JUP") (collectively referred to as "Jefferson"). In addition, by signing below, I authorize Jefferson to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Parent/Legal Guardian)

**INABILITY TO OBTAIN ACKNOWLEDGEMENT**

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

\_\_\_\_\_ Individual refused to sign

\_\_\_\_\_ An emergency situation prevented us from obtaining the acknowledgement

Signature of Jefferson Representative: \_\_\_\_\_

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