Noble Public Schools/Norman Regional Health System Partnership

Dear Parents and Guardians,

Noble Public Schools, Norman Regional Health System, and the Norman Regional Health Foundation have partnered together to provide Norman Regional Kids Virtual Care, a program where your child can see a board certified physician or licensed provider during school hours from the school nurse office.

We are proud to offer this convenient program to Noble Public Schools. To participate, registration in Norman Regional Kids Virtual Care by the parent/guardian is required.

How does it work?

With the parent or legal guardian's permission, a student may be evaluated by a board certified physician or licensed provider through a virtual visit. The school health provider will use a Telemed Tablet (which is like an iPad) to video conference with the provider. Under the guidance of the provider, the school health assistant will assist the provider during the evaluation through the use of digital devices such as a stethoscope, otoscope, and dermatoscope. For example, the provider can listen to the child's lungs through the digital stethoscope operated by the school health assistant. If the provider believes the child needs a prescription, it can be called in to the pharmacy of choice listed on the child's program enrollment form. Parents have the option of being part of the virtual visit through video conferencing from their smart phone or tablet wherever they are at the time the child needs medical attention.

This program also has the capability to perform a rapid flu or rapid strep test in the school nurse office. Under the guidance of a provider, the school nurse will take either a nasal, nasopharyngeal, or throat swab and a rapid test will return results in about 15 minutes. This helps the provider know if a student has a bacterial or viral infection, and thus what medications need to be prescribed if applicable.

Common conditions that can be treated through a virtual visit:

- Ear infections
- Sore throats
- Pink eye
- Flu
- Sinus infections
- Upper respiratory infections
- Allergic rhinitis
- Asthma flare-ups
- Skin rashes

2020 - 2021 Noble Public Schools
Norman Regional Kids Virtual Care
Enrollment and Consent Form

Student/Patient Information:

Student name: _____ ☐ Female ☐ Male

Student date of birth: _____ Age: _____ School: _____

Student Allergies: _____
(include: medications, food, animals/insects and seasonal allergies)

Student's legal guardian(s): ☐ Mother ☐ Father ☐ Other _____

Student lives with: ☐ Mother ☐ Father ☐ Other _____

Legal parent/guardian contact information:

Parent/Guardian's name: _____

Phone number: _____ Alternate phone number: _____

Relationship to student: ☐ Mother ☐ Father ☐ Other _____

Parent/Guardian's name: _____

Phone number: _____ Alternate phone number: _____

Relationship to student: ☐ Mother ☐ Father ☐ Other _____

Email address: _____

Student's Pediatrician/Physician: _____ Phone number: _____

Preferred Pharmacy: _____
Name Address City State Zip

I consent and authorize my student to receive care and/or treatment through Norman Regional Kids Virtual Care at school. I have read or have had read to me the following consent for Norman Regional Kids Virtual Care and acknowledge understanding.

Parent/Guardian Signature*: _____ Date: _____
*Or student's signature if 18 years of age

Consent for Norman Regional Kids Virtual Care
Financial Responsibility

Student name: _____ **Student date of birth:** _____

In some instances, we may be able to bill your insurance. Please complete the information below if you would like us to bill your insurance. In the event your insurer does not cover a virtual visit, you will not be charged for the visit.

Name of person responsible for paying the bill: _____

Primary phone number: _____ Relationship to student: ☐ Mother ☐ Father ☐ Other _____

Date of birth: _____ Address: _____

Name of insurance policy holder: _____ Date of birth: _____

Policy holder address: _____

Employer: _____ Insurance Name: _____

Insurance phone number: _____ Insurance ID#: _____

Insurance Group #: _____

Financial Responsibility and Assignments - Financial Responsibility: I agree to pay for the full billed charges associated with goods and services provided to my student ("Patient") regardless of any applicable insurance or benefit payments and understand that all amounts are due upon request and are payable to Norman Regional Health System and any provider who provides services to Patient at a Norman Regional Health System hospital, facility, entity or program (collectively referred to as the ''Provider(s)''). Except as prohibited by law, I agree to pay for any charges not covered and covered charges not paid in full by any applicable insurance and / or benefit plan including charges payable as co-insurance, deductibles, and non-covered benefits due to policy and / or plan limitations, exclusions, and / or failure to comply with insurance and / or plan requirements. An estimate of the anticipated charges is available upon request. I understand that estimates may vary significantly from the final charges because of a variety of factors such as the course of treatment, intensity of care, Provider practices, and the need to provide additional goods and services. I also agree and understand that if Patient's account becomes delinquent and is referred to an attorney or agency for collection or suit, I will be responsible for paying all charges, reasonable attorney fees, costs, and collection expenses. I consent to credit bureau inquiries and to receiving auto-dialed, computer generated and pre-recorded message calls to my cellular telephone and to any telephone number provided during Patient's enrollment process from Norman Regional Health System Providers, and their affiliates and agents including, without limitation, any account management companies, independent contractors, or collection agents.

Medicare / Medicaid Patients Only: I understand that the goods and services that I request to be provided to Patient may not be covered under Medicare / Medicaid as being reasonable and medically necessary for Patient's care. I understand that Medicare / Medicaid or their insuring agent determine the medical necessity of the goods and services requested for Patient. If Medicare / Medicaid determine that certain goods and services are not medically necessary for Patient's care and I request such goods and services be provided despite Medicare / Medicaid's denial, I understand I am solely responsible for payment for those goods and services. If Patient is a Medicare / Medicaid managed care Patient, these provisions may not apply. I certify that the information given by or on behalf of Patient in applying for payment under Medicare / Medicaid is correct. I authorize the release of medical or other information about Patient to the Social Security Administration, intermediaries, or carriers as needed for Medicare / Medicaid claims.

Assignment of Benefits: I irrevocably assign and convey directly to Norman Regional Health System, and any Provider, all benefits and all interest and rights, including any causes of action, ERISA (Employee Retirement Income Security Act) breach claim or other legal / administrative claim and the right to enforce payment, under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from another payor providing benefits on Patient's behalf for goods and services provided to Patient by Norman Regional Health System and Providers. I also authorize direct payment to Norman Regional Health System and

Providers for the goods and services Norman Regional Health System and Providers provide to Patient. I authorize Patient's plan administrator, insurer, and / or attorney to release to Norman Regional Health System and Providers all plan documents, summary benefit description, insurance policy, and settlement information upon written request from Norman Regional Health System or Providers needed to claim medical benefits.

Under this assignment, I convey to Norman Regional Health System and Providers all of my rights to claim or place a lien on benefits related to goods and services provided by Norman Regional Health System and Providers to Patient, including rights to any settlement, insurance or applicable legal or administrative remedies, including damages arising from ERISA breach claims, and the right to appeal or pursue any denied or delayed claims. Norman Regional Health System and Providers have the right to: (1) obtain all information regarding the claim; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; and / or (5) participate in any administrative and judicial actions and pursue claims, a cause of action, or right against any liable party, insurance company, benefit plan, or plan administrator. Norman Regional Health System and Providers may bring suit against any such benefit plan, plan administrator or insurance company in my name and / or Patient's name with derivative standing. This assignment is not and shall not be construed as an obligation of Norman Regional Health System and/or Providers to pursue such interest and rights.

I have read or have had read to me this Consent for Norman Regional Kids Virtual Care – Financial Responsibility and acknowledge understanding.

_____ _____

Signature of Parent or Legally Authorized Representative Date
Or student if 18 years of age

_____ _____

Printed Name of Parent or Legally Authorized Representative Date
Or student if 18 years of age

Consent for Norman Regional Kids Virtual Care
Consent for Care and Treatment

Student name:_____ **Student date of birth:** _____

Consent for Norman Regional Kids Virtual Care and Treatment

General Consent: I consent for my child or a child for whom I have legal responsibility ("Patient"), to receive care from a board-certified pediatrician through Norman Regional Kids Virtual Care (which may also be referred to as a virtual visit). Virtual visits may include the evaluation, diagnosis, consultation, and treatment of Patient's medical or health condition using advanced telecommunications technology. A virtual visit may also include a rapid flu or rapid strep test, performed at the school under the supervision of a physician. Testing will be done by the school health assistant at the discretion of the physician. I agree that by signing this form, I consent for Patient to receive a virtual visit in my absence. I understand that photos or video of the Patient may be taken in connection with the virtual visit but will not be stored after the virtual visit concludes.

I understand that Norman Regional Kids Virtual Care includes interactive audio, video, or other electronic media and that there are both risks and benefits to being treated via virtual care. I understand that with virtual visits, the pediatrician (i) will be in a location other than where Patient is located, (ii) will examine Patient face-to-face via a remote presence but will not perform a ''hands-on'' physical examination, and (iii) must rely on information provided by Patient and the school health nurse. A "hands-on" physical examination may be performed by the school health nurse through peripheral devices, which include digital, Bluetooth enabled devices such as a stethoscope, dermatoscope, otoscope, pulse oximeter, thermometer, blood pressure cuff, and scale. The provider may ask the school health nurse to use these devices on the Patient for further evaluation. I further understand that the virtual visit may be limited or unavailable as a result of technological or equipment failures, incomplete or inaccurate information to perform the virtual visit, or distortions of images or other information from electronic transmissions. I acknowledge that the pediatrician cannot be held liable for advice, recommendations and/or decisions based on factors not within their control, such as incomplete or inaccurate information provided by Patient/others or distortions of diagnostic images or specimens that may result from electronic transmission.

If the provider determines that the virtual visit does not adequately address the Patient's medical needs, the provider will recommend to parent or guardian a referral for on-site medical evaluation at an appropriate provider location, such as a primary care physician/pediatrician's office, an urgent care center, or an emergency department. If after the virtual visit, Patient experiences an urgent or emergent matter, such as a negative reaction to any treatment, or if the virtual visit is interrupted due to a technological or equipment failure, alternative treatment may be needed.

I understand that precautions are taken to protect the confidentiality of Patient's medical information by preventing unauthorized disclosure; however, I understand and acknowledge that the security of electronic transmission of data, video images, and audio information cannot be guaranteed and confidentiality may be compromised by illegal or improper tampering.

Norman Regional Health System Providers: No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided through Norman Regional Kids Virtual Care. I understand that all supplies, medical devices, and other goods are my responsibility to acquire.

Protected Health Information - Notice of Privacy Practices: Norman Regional Health System's Notice of Privacy Practices addresses how Norman Regional Health System may use and disclose Patient's Protected Health Information (PHI) for treatment, healthcare operations and for other purposes allowed or required by law. I acknowledge that I have received Norman Regional Health System's Notice of Privacy Practices and that any questions or concerns may be directed to the Norman Regional Health System's Privacy Officer.

Use and Disclosure of information: I understand that Patient's virtual visit summaries are confidential and cannot be disclosed without my written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices. I understand that Patient's medical information includes past, present, and future information, including the 2019-2020 Noble Public Schools Student Health History form. I authorize release of that medical information as part of Patient's visit summary. I understand that Noble Public Schools must keep Patient's Student Health History form for a time period required by law and then may dispose of such records as permitted or required by law. I understand that Norman Regional Health System will retain a copy of Patient's Norman Regional Kids Virtual Care enrollment form.

Student name:_____ **Student date of birth:** _____

I authorize Norman Regional Health System and Providers to use Patient's medical information for the purposes of treatment, payment, healthcare operations, or as otherwise allow by law. I acknowledge that Norman Regional Health System will release and send, electronically or otherwise, Patient's medical information to third parties for the purposes set forth above, or as otherwise allowed by law. I understand that Patient's medical information may no longer be protected by federal and state privacy laws once it is disclosed, and therefore, may be subject to re-disclosure by the recipient. Medical information may become part of Patient's medical records kept by non-Norman Regional Health System healthcare providers and may be further disclosed.

Duration of Consent: I understand and agree this Consent for Norman Regional Kids Virtual Care is valid for the current school year from the date of signature below unless I revoke the consent prior to that time.

I have read and understand the information in this Consent for Norman Regional Kids Virtual Care and Treatment form.

I have read and understand the information in the Acknowledgments for Protected Health Information and have received Norman Regional Health System's Notice of Privacy Practices.

☐ Please contact me before proceeding with a virtual visit and do not proceed with a visit until you have spoken with me.

☐ You have my consent to proceed with a visit in the event I am unable to be reached.

☐ Please share any Norman Regional Kids Virtual Care visit summaries with my student's pediatrician/physician.

_____ _____

Signature of Parent or Legally Authorized Representative Date
Or student if 18 years of age

_____ _____

Printed Name of Parent or Legally Authorized Representative Date
Or student if 18 years of age

Student name:_____ **Student date of birth:** _____

Frequently Asked Questions

Who will see my child?
A board certified pediatrician or a licensed provider.

Can I be there for the virtual visit?
Yes, the parent/guardian can be part of a three-way video call that includes the provider and the school health provider with the child.

What if I'm not available for the virtual visit?
Your child can still be seen through a virtual visit without a parent/guardian present as long as you have signed the consent form. If you prefer, the provider will call you prior to the visit, so that you can be included. You can check the box on page 5 to request a call to you prior to the virtual visit. If the parent/guardian cannot be reached, the virtual visit will only occur if you check the appropriate box on page 5.

Why do I have to sign the consent form before the visit?
Signing the consent form in advance is convenient for you, the parent/guardian and ensures your child can be seen quickly. If the form is not signed in advance, the school health nurse would have to email/fax a copy to the parent/guardian and the parent/guardian would have to complete the form and return it to the school health nurse at the time of the visit.

Will I be given a visit summary after my child's visit?
Yes, you will receive a summary of your child's visit through the Parent Portal. If you would like us to share your child's visit summary with their pediatrician, please check the corresponding box and provide a signature on page 5 of this packet.

Can I or other family members use this service?
At this time, Norman Regional Kids Virtual Care is only for students who attend Noble Public Schools. If you or a family member needs a virtual visit for urgent care, you can download the Norman Regional Virtual Care app to see a physician 24/7. You can also find a Norman Regional Primary Care Physician by calling 405-515-5000.

How do you know if my child has strep or the flu?
We now have the capability to perform a rapid strep or rapid flu test in the school health assistant's office. Under the guidance of a provider, the school health assistant will take either a nasal, nasopharyngeal, or throat swab and a rapid test will return results in about 15 minutes. This helps the provider know if a student has a bacterial or viral infection, and thus what medications need to be prescribed if applicable.

Will my child get prescription medication if needed?
If the provider determines your child needs a prescription, the provider will send it to the pharmacy listed on the child's program enrollment form. Please note that not all Norman Regional Kids Virtual Care visits will result in a prescription order.

What are peripheral devices?
Peripheral devices are digital, Bluetooth-enabled diagnostic devices such as a stethoscope, dermatoscope, otoscope, thermometer, pulse oximeter, blood pressure cuff, and scale. The school health nurse can examine your child with these devices and the provider can remotely see and hear the results, allowing for a more thorough evaluation of the child.

What happens if the virtual visit cannot be completed?
If it turns out that your child needs more care or an in-person visit, the provider will refer you to your family physician, an urgent care, or an emergency department as needed.

How do I sign my child up for Norman Regional Kids Virtual Care?
You may sign up during enrollment or any time during the school year through the school nurse. More information and consent forms may be found at your school and through the school nurse.

What is the cost of the Norman Regional Kids Virtual Visit program?
We will bill your insurance if possible and you may be subject to a co-pay.

What if my child does not have a pediatrician?
If you do not have a primary care provider, please visit normanregional.com/pediatricians to see a list of pediatricians in the area.

I have read and understand the Frequently Asked Questions regarding Norman Regional Kids Virtual Care.

Parent/Guardian Signature:_____ Date: _____
Or student's signature if 18 years of age

Noble Public Schools and Norman Regional Health System have partnered together to provide Norman Regional Kids Virtual Care, a program where your child can see a board-certified pediatrician or licensed provider during school hours from the school nurse office.

We are proud to offer this convenient program to Noble Public Schools. **Registration in Norman Regional Kids Virtual Care by the parent/guardian is required.**

NORMAN REGIONAL Health System | Kids Virtual Care

Noble Public Schools

Norman Regional Kids Virtual Care

Norman Regional Health System provides the enclosed Notice of Privacy Practices to all patients. We are required by federal law to give this document to all patients. Much of this information focuses on how we handle patient health information within our inpatient and outpatient settings.

Since your child will be seen by a Norman Regional provider as part of Norman Regional Kids Virtual Care, we are required to provide this document. Please note that the only information within the privacy practices related to this program is protecting your child's health information. The information that Norman Regional is required by law to keep on our secure server is noted below:

- Your child's enrollment form
- Your child's consent form
- A summary of each visit

Thank you for trusting us with your child's healthcare needs.

NORMAN REGIONAL Health System | Kids Virtual Care

NORMAN REGIONAL Health System

NOTICE OF PRIVACY PRACTICES

Effective Date: December 8, 2017

Original Date: 4/4/2003 Revisions: 3/12/07, 11/1/10, 9/1/13

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.

NORMAN REGIONAL HEALTH SYSTEM (NRHS) and all of its affiliated entities (collectively referred to as "**NRHS**") are committed to protecting your medical information. We are required by law to:

- Maintain the privacy of your medical information;
- Give you a notice of our legal duties and privacy practices with respect to your medical information; and
- Follow the terms of the notice currently in effect.

What is this document?

This Notice of Privacy Practices describes how we may use and disclose your medical information. It also describes your rights to access and control your medical information.

What does this Notice cover?

This Notice of Privacy Practices applies to all of your medical information used to make decisions about your care that we generate or maintain, including sensitive information such as mental health, communicable disease and drug and alcohol abuse information. It applies to your medical information in written and electronic form. Different privacy practices may apply to your medical information that is created or kept by other people or entities.

Who does this Notice cover?

This Notice of Privacy Practices will be followed by all **NRHS** employees; any health care professional who provides treatment to you at **NRHS**; and any member of a volunteer group that provides services at **NRHS**.

What will you do with my medical information?

The following categories describe the ways that we may use and disclose your medical information without obtaining your prior written authorization. Not every use or disclosure in a category will be listed.

If you are concerned about a possible use or disclosure of any part of your medical information, you may request a restriction. Your right to request a restriction is described in the section below regarding patient rights.

Treatment. We will use your medical information to provide you with medical treatment and services.

We maintain medical information about our patients in an electronic medical record that allows us to share medical information for treatment purposes. This facilitates access to medical information by other health care providers who provide care to you.

Example: Your medical information may be disclosed to doctors, technicians, nurses, students or other personnel who are involved in taking care of you.

We may disclose your medical information for the treatment activities of any other health care providers.

Example: We may send a copy of your medical record to a physician who needs to provide follow-up care.

Payment. We may use medical information about you for our payment activities. Common payment activities include, but are not limited to:

- Determining eligibility or coverage under a plan; and
- Billing and collection activities.

Example: Your medical information may be released to an insurance company to obtain payment for services.

We may disclose medical information about you to another health care provider or covered entity for its payment activities.

Example: We may send your health plan coverage information to an outside laboratory that needs the information to bill for tests that it provided to you.

Operations. We may use your medical information for operational or administrative purposes. These uses are necessary to run our business and to make sure patients receive quality care. Common operation activities include, but are not limited to:

- Conducting quality assessment and improvement activities;
- Reviewing the competence of health care professionals;
- Arranging for legal or auditing services;
- Business planning and development;
- Business management and administrative activities; and
- Communicating with patients about our services.

Example: (1) We may use your medical information to conduct internal audits to verify that billing is being conducted properly. (2) We may use your medical information to contact you for the purposes of conducting patient satisfaction surveys or to follow-up on the services we provided.

We may disclose medical information about you to another health care provider or covered entity for its operation activities under certain circumstances.

Health Information Exchange. We may participate in a health information exchange (HIE). Generally, an HIE is an organization in which providers exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical error will occur. By participating in a HIE, we may share your health information with other providers that participate in the HIE or participants of other health information exchanges. If you do not want your medical information to be available through the HIE, you must request a restriction using the process outlined in the "Right to Request Restrictions" section.

Communicable Diseases. Oklahoma law only permits disclosure of communicable disease information (such as HIV, AIDS, Hepatitis, etc.) under the following circumstances: (i) with the patient's written authorization; (ii) if release is ordered by a court; (iii) if release is required by the State Department of Health to protect the public; (iv) if release is made to a person exposed to such diseases; (v) if release is required to health professionals, appropriate state agencies or a court to enforce Oklahoma law; (vi) if release is required for statistical purposes without patient identity, (vii) if release is required to health care providers and related parties for diagnosis and treatment purposes; or (viii) when the patient is an inmate in the custody of the Department of Corrections or related party and such release is necessary to (a) prevent serious and imminent threat to a person or the public, or (b) permit law enforcement authorities to identify an individual suspected of having escaped from a correctional institution.

Business Associates. We may disclose your medical information to other entities that provide a service to us or on our behalf that requires the release of patient medical information. However, we only will make these disclosures if we have received satisfactory assurance that the other entity will properly safeguard your medical information.

Example: We may contract with another entity to provide transcription or billing services.

Treatment Alternatives. We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend, family member or legal guardian who is involved in your medical care. We may tell your family or friends your condition and that you are in the hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Directory. We may include certain information about you in our directory while you are a patient at **NRHS**. This information may include your name, location in **NRHS**, your general condition and your religious affiliation. The directory information, except for your religious affiliation, may 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 minister, priest or rabbi, even if they do not 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. If you do not want to be in our directory, you will need to notify **NRHS** personnel at registration. You will be asked to complete an "opt out" form.

Organ and Tissue Donation. If you are an organ donor, we may release medical 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.

Research. We may use and disclose medical information about you to researchers. In most circumstances, you must sign a separate form specifically authorizing us to use and/or disclose your medical information for research. However, there are certain exceptions. Your medical information may be disclosed without your authorization for research if the authorization requirement has been waived or altered by a special committee that is charged with ensuring that the disclosure will not pose a great risk to your privacy or that measures are being taken to protect your medical information. Your medical information also may be disclosed to researchers to prepare for research as long as certain conditions are met.

Medical information regarding people who have died can be released without authorization under certain circumstances. Limited medical information may be released to a researcher who has signed an agreement promising to protect the information released.

Fundraising. We may use medical information about you to contact you in the future to raise money for **NRHS**. We may disclose medical information to a foundation related to **NRHS** so that the foundation may contact you to raise money on our behalf. We only will release limited information, such as your name, address and phone number, the dates you received treatment or services at **NRHS**, the department in which you received services, your treating physician and your health insurance status for fundraising purposes. Each solicitation will include information on how to opt-out of receiving further fundraising communications from **NRHS**. You also may notify **NRHS**, in writing, addressed to the Norman Regional Health Foundation, PO Box 1308, Norman, Oklahoma 73070-1308, to opt-out of receiving further fundraising communications.

Can you ever use and disclose my medical information without my authorization?

Yes. The following categories describe the ways that we may be required to use and disclose your medical information without your authorization. Not every use or disclosure in a category will be listed.

Required by Law. We may disclose your medical information when required to do so by federal, state or local law.

Example: (1) We may release your medical information for workers' compensation or similar programs. (2) We are required by law to report cases of suspected abuse and neglect. These reports may include your medical information.

Deceased Information. Your medical information may be released, after your death, to a personal representative as defined by state law. It may also be released to family members and others who are involved in your care to the extent permitted by state law, unless doing so is inconsistent with any of your prior expressed preferences that are known to us. We may also disclose a deceased patient's medical information without authorization to a healthcare provider who is treating a surviving relative for a similar medical condition such as an inherited disease.

Public Health. We may disclose medical information about you for public health activities intended to:

- Prevent or control disease, injury or disability;
- Report births and deaths;
- Report abuse, neglect or violence as required by law;
- Report reactions to medications or problems with products;
- Notify people of recalls of products they may be using; or
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Public Safety. We may use and disclose medical information about you 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 would only be to someone able to help prevent the threat.

Food and Drug Administration (FDA). We may disclose to the FDA and to manufacturers health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacements.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. In limited circumstances, we may disclose medical information about you in response to a subpoena or discovery request.

Law Enforcement. We may release medical information if asked to do so by law enforcement official:

- In response to a court order, warrant, summons or other 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 person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; 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 release medical information to a coroner or medical examiner.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Military/Veterans. We may disclose your medical information as required by military command authorities, if you are a member of the armed forces.

Inmates. If you are an inmate of a correctional facility or under the custody of a law enforcement official or agency, we may release your medical information to the correctional facility or law enforcement official or agency.

What if you want to use and/or disclose my medical information for a purpose not described in this Notice? We must obtain a separate, specific authorization from you to use and/or disclose your medical information for any purpose not covered by this notice or the laws that apply to us. If you provide us with authorization to use or disclose your medical information, you may revoke the authorization, in writing, at any time.

If you revoke your authorization, we will not use or disclose your medical information for the reasons covered by your authorization. However, your revocation will not apply to disclosures already made by us in reliance on your authorization.

Your authorization is required for the following purposes:

- **Psychotherapy notes.** We must obtain your authorization to use or disclose notes maintained by a mental health professional about a counseling session.
- **Sale of Medical Information.** We must obtain your authorization virtually any time we intend to sell your medical information, with minor exceptions.
- **Marketing.** We must obtain your authorization to communicate with you about a particular product or service virtually any time we are paid to make the communication, with minor exceptions.

What are my rights regarding my medical information?

You have the rights described below in regard to the medical information that we maintain about you. You are required to submit a written request to exercise any of these rights. You may contact our medical record department or Privacy Official to obtain a form that you can use to exercise any of the rights listed below.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of medical information used to make decisions about your care. We will provide you with access to your medical information in the form or format requested if it is available in such format. We may charge a fee for the costs associated with your request, including the cost of copies, postage or other supplies, consistent with state law. We may deny your request to inspect and/or copy your medical information in certain circumstances. If you are denied access, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your original request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information that we created is incorrect or incomplete, you may submit a request for an amendment for as long as we maintain the information. *You must provide a reason that supports your amendment request.*

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 to amend information that:

- We did not create, unless the person or entity that created the information is not available to make the amendment;
- Is not part of the medical information that we maintain;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request one free "accounting of disclosures" every 12 months. This is a list of certain disclosures we made of your medical information. There are several categories of disclosures that we are not required to list in the accounting. For example, we do not have to keep track of disclosures that are authorized. *Your request must state a time period, which may not be longer than 6 years and may not include dates before April 14, 2003.* If you request more than one accounting in a 12-month period, we may 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 Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you unless our use and/or disclosure is required by law. You also have the right to request a limit on the medical 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. You can request a restriction if you do not want us to disclose your medical information to an HIE.

We are not required to agree to your request ***unless you are requesting a restriction on the disclosure of information to your health plan and you pay out of pocket for the medical treatment provided.*** If we agree to a restriction, we will comply with your request unless the information is needed to provide emergency treatment to you.

In your request, you must indicate:

- The type of restriction you want and the information you want restricted; and
- To whom you want the limits to apply, for example, your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical 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. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. Copies of this notice always will be available in our medical record department.

Can you change this notice?

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. Copies of the current notice will be posted at **NRHS** and will be available for you to pick up on each visit to **NRHS**.

What happens if my medical information is used by or disclosed to a person or entity that should not have access to it?

We are required to notify you of any acquisition, access, use, or disclosure of your medical information that is inconsistent with the federal law governing the protection of medical information (known has HIPAA).

What if I have questions or need to report a problem?

If you believe your privacy rights have been violated, you may file a complaint with us or with the Office of Civil Rights of the Department of Health and Human Services. To file a complaint with us, or if you would like more information about our privacy practices, contact **NRHS's Privacy Officer at (405) 307-1405 or by mail at 901 N Porter Ave, Norman, OK 73071.** To file a complaint with the Office of Civil Rights of the Department of Health and Human Services, you must submit the complaint within 180 days of when you knew or should have known of the circumstance that led to the complaint. The complaint must be submitted in writing. Information on how to file a complaint can be located on the Office of Civil Rights website at: http://www.hhs.gov/ocr/privacy/index.html or our Privacy Official can provide you with current contact information. ***You will not be penalized for filing a complaint.***

Discrimination is Against the Law.

Norman Regional Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Norman Regional Health System does not exclude people or treat them differently because of race, color, national origin, age, disability, sex or gender identity. Norman Regional Health System:

1) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)
2) Provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages

For assistance with these services please contact the Patient Liaison (405-307-1060) or the Compliance/Regulatory Officer (405-307-1405).

If you believe that Norman Regional Health System has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex or gender identity you can file a grievance with:

Patient Liaison – 901 N. Porter. Norman, OK 73071

- Phone: 405-307-1060 • Fax: 405-307-1433
- Email: NonDiscrimination@nrh-ok.com

If you have questions on how to file a grievance related to discrimination you may contact the Patient Liaison (405-307-1060) or the Compliance/Regulatory Officer (405-307-1405).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Dallas Office: U.S. Department of Health and Human Services – Office of Civil Rights, 1301 Young Street Ste 1169, Dallas, TX 75202 • www.hhs.gov/ocr • 1-800-368-1019 or TDD 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.951200007.0913

English

ATTENTION: If you speak english, language assistance services, free of charge, are available to you. Call 1-405-307-1060.

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-405-307-1060).

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-405-307-1060.

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-405-307-1060.

မြန်မာ (Burmese)

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဥ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-405-307-1060

اُردو (Urdu)

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں ۔ 1-405-307-1060

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-405-307-1060.

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-405-307-1405.

tsalagi gawonihisdi (Cherokee)

Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-405-307-1060.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-405-307-1060.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-405-307-1060.

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-405-307-1060 تماس بگیرید.

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-405-307-1060.

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-405-307-1405.

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-405-307-1060.

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-405-307-1060.