

JOINT NOTICE OF PRIVACY PRACTICES

This Joint Notice of Privacy Practices (“Notice”) describes how medical information about you may be used and disclosed and how you can get access to this information. This Notice applies to all health information created or received by the medical staff, health care workers, employees, contract staff, students, trainees, and volunteers at Northwest Kidney Centers (“NKC”).

For purposes of complying with the Health Information Portability and Accountability Act (“HIPAA”), NKC and its medical staff, which includes members of the Division of Nephrology from the University of Washington, designate themselves an Organized Health Care Arrangement (“OHCA”). They may share health information with each other for treatment, payment, and health care operations of the OHCA and as described in this Notice.

Personal Health Information About You

The following list identifies the different ways we may use and disclose your health information. In most cases, we will use and disclose only the minimum health information necessary for the purpose.

Treatment, Payment, and Health Care Operations

To Treat You: We may use and share health information about you to give you care and to manage your treatment or other services. For example, we may tell a doctor needing to perform surgery on you that you are on dialysis.

To Be Paid for Our Services: We may use and share health information about you to bill and collect payment for services received. We will get your authorization to disclose this information. For example, we may submit a bill to your health plan for care we provided you.

For Our Operations: We may use and disclose information about you to run our business. For example, we may use health information about you to review the quality of care we are providing.

Uses and Disclosures When You Do Not Object

We may use and disclose health information about you for the purposes below, but only after you have had the chance to object, unless otherwise permitted by law.

- To family and friends who are involved in your care or to notify family and friends of your condition or location.
- To provide directory information (for example, to confirm you are in our facility).
- For emergency and notification purposes, such as to a disaster relief agency to coordinate disaster relief efforts.

Uses and Disclosures of Health Information Not Requiring Your Permission

We may use and disclose health care information for the following reasons without your permission.

- For public health and safety.
- For health and safety oversight activities.
- To other entities that we contract to assist us. We require these entities to protect the privacy and confidentiality of your health information.

- Incidental disclosures that happen during permitted uses and disclosures, such as someone in the waiting room hearing your name called.
- For education. We may send educational materials and newsletters to you to keep you informed about your care.
- For fundraising. We may contact you as part of a fundraising effort, but **you have the right to tell us you do not wish to receive fundraising communications.**
- To avert a serious threat to health or safety.
- For a court order, subpoena, search warrant, or other legal or law enforcement purpose.
- As de-identified information or part of a limited data set, after removing information that could be used to identify you, as allowed by law.
- To organ procurement organizations or persons who obtain, store, or transplant organs.
- For specialized government functions, such as for national security purposes.
- To correctional institutions, if you are in prison or in police custody.
- To report suspected child abuse or neglect or other abuse or neglect.
- To military or veterans' authorities if you are or were affiliated with the military.
- To coroners, medical examiners, or funeral directors to perform their duties.
- To comply with workers' compensation laws for workers' compensation claims.
- To personal representatives for minors and incapacitated adults.
- As otherwise required by law.

Additional Protections

We provide additional protections to your health information and may need your permission, as required by law, to share information related to AIDS/HIV, sexually transmitted and another communicable disease, drug and alcohol abuse, and mental health services.

Authorization

Other uses and disclosures will be made only with your authorization. For example, we need your permission to use and disclose health information for marketing; if we are receiving something of value for the health information; or psychotherapy notes. In most cases, you have the right to revoke or cancel your authorization, in writing, at any time.

Your Rights

You have personal rights concerning your health information. You may act on these rights by contacting your Northwest Kidney Centers Social Worker or the Northwest Kidney Centers privacy officer at:

Compliance & Privacy Officer
Northwest Kidney Center
12901 20th Avenue South
SeaTac, WA 98168
Phone: 206-720-8806
PrivacyOfficer@nwkidney.org

- You can file a complaint with at:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.,
Washington, D.C. 20201
Phone: 877-696-6775
<https://www.hhs.gov/hipaa/filing-a-complaint/index.html>

We will not retaliate against you for filing a complaint.

Additional Rights

Ask us to limit the information that we use and share: You have the right to ask us in writing to limit uses or disclosures of information about you for treatment, payment, and business purposes. We may deny your request in certain situations.

Request confidential communications: You have the right to receive confidential communications in other ways or at other locations. This includes a different mailing address or an email address.

Inspect and copy: In most cases, you have the right to look at health information about you or request a paper or electronic copy. You also may ask us to send an electronic copy of your health information to another person if your request is in writing, signed by you, and clearly says who the person is where to send the health information. We may charge a reasonable, cost-based fee.

Request changes: You have the right to request that we correct information in your record or add information you believe is missing. We may deny your request in certain situations.

Know about disclosures: You have the right to ask for and receive a list (called an accounting) of times where we have disclosed information about you, except for disclosures for treatment, payment, related business purposes, or other disclosures specified by law.

Receive a copy of this Notice: You have the right to receive a paper copy of this Notice, even if you received an electronic copy of this Notice.

Our Duties

We are required by law to keep health information about you private. We must give you this Notice of our legal duties and privacy practices, and we must follow the practices that are stated in the Notice. We will notify you if there is a breach of unsecured health information about you.

Changes to This Notice

We reserve the right to change this Notice. The revised Notice will be effective for information we already have about you as well as any information we receive in the future. Unless required by law, the revised Notice will be effective on the new effective date of the Notice. For a copy of the current Notice, please ask at one of our registration areas. The current Notice also is posted on our website (www.nwkidney.org) and in our facilities. The notice will state an effective date.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I am a patient or a personal representative of a patient of Northwest Kidney Centers. By signing this form, I acknowledge that I have been offered a copy of the Northwest Kidney Centers Joint Notice of Privacy Practices.

Name: _____
(Please Print)

Signature: _____

Date: _____

OR

I am the parent or legal guardian of:

(patient name)

I hereby acknowledge that I have been offered a copy of the Northwest Kidney Centers Joint Notice of Privacy Practices with respect to the above-named patient.

Name: _____
(please print)

Relationship to Patient (please check one):

☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____