Riley County Health Department

INFLUENZA VACCINE REGISTRATION FORM

PATIENT INFORMATION

Patient's First Name | Middle Name | Last Name

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name(s))	Birth Date / /	Age	Sex ❑ M ❑ F

Race: ❑ Asian/Pacific Islander/Other ❑ Black or African American ❑ Caucasian or White ❑ Native American/Alaska Native ❑ Hawaiian ❑ Unknown or Other

Ethnicity: Hispanic/Latino?: ❑ Yes ❑ No

Current Address	City	State	ZIP Code

Cell Phone No. (text appointment reminders) ( )	Home Phone No. ( )	Email Address:

IN CASE OF EMERGENCY

Name of Emergency Contact	Relationship to Patient	Phone No. ( )	Additional Phone No. ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Is this patient covered by insurance? ❑ Yes ❑ No | Are immunizations covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance (Blue Cross, Aetna, Sunflower, etc.):

Subscriber's Name	Subscriber's Birth Date / /	Policy #	Group #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IMMUNIZATION SCREENING QUESTIONNAIRE

1.	Is the person to be vaccinated currently sick or experiencing a high fever? If yes, please explain:	☐ Yes ☐ No
2. 3.	Does the person to be vaccinated have allergies to medications, food, a vaccine component, or latex? If yes, please list:	☐ Yes ☐ No
4. 5.	Has the person to be vaccinated had a serious reaction to a vaccine in the past? If yes, please explain:	☐ Yes ☐ No
6.	Has the person to be vaccinated ever had Guillain-Barré syndrome (neurological disorder)?	☐ Yes ☐ No
7.	Is the person to be vaccinated 19 years of age or older with one or more of the following medical conditions (recommend Flublok); pregnant (or thinking about becoming pregnant in the next year), asthma, chronic lung disease (COPD, cystic fibrosis), chronic heart disease (congestive heart failure, coronary artery disease), diabetic, obese, or have a weakened immune system (HIV, cancer, chronic steroids), or have another chronic (on going) medical condition not listed **(FluBlok Screening)**? **If so, please circle or list here…**	☐ Yes ☐ No ☐ < 19 years

VACCINE CONSENT

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I understand and am aware I am advised to wait for 15 to 30 minutes post vaccination for monitoring. I ask that the vaccine(s) checked be given to me or to the person named above for whom I am authorized to make this request. ☒ Influenza

Signature of Patient or Legal Parent/Guardian: Date:

FOR OFFICE USE ONLY

Eligibility Screening	Nursing Documentation			Billing & Coding		
❑ **Title 19 (Public)**	**Manufacturer:**			**90662**	**High Dose (65+)**	**($65)**
❑ **Title 21 (Public)**	**Lot Number:**	*(place syringe sticker here)*		**90682**	**FluBlok (RIV4) (18+)**	**($65)**
❑ ***UN*insured ≤ 18 (Public)**	**Expiration Date:**			**90686**	**Fluarix**	**($21)**
❑ **Nat Am/Al Nat (Public)**				**317FLU**	**317 Flu Vaccine**	**($0)**
❑ ***UNDER*insured (Public)**	**Injection Site:**	Left	Deltoid			
❑ **Fully Insured (Private)**		Right	Vastus Lateralus	**90471**	**1st Injection**	**($20)**
❑ ***UN*insured ≥ 19 (Out of Pocket)**	**Inadvertently Borrowed Stock (Explain):**			**G0008**	**Medicare Injection**	**($20)**
❑ ***UN*insured ≥ 19 (317)**				**90471G**	**Grant Injection**	**($0)**

Vaccine Administrator: **Date:**

RILEY COUNTY Health Department

Riley County Health Department
2030 Tecumseh Rd
Manhattan, Kansas 66502
Phone: 785-776-4779
Fax: 785-565-6566
www.rileycountyks.gov/health

Universal Consent Form

BILLING

By my signature below, I authorize the Riley County Health Department to bill any of the medical payers as indicated and provide necessary information to process claims. I authorize payment of medical benefits to the Riley County Health Department for services rendered and I understand I will be responsible for payment of charged deemed "uncovered" by my health insurance. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Riley County Health Department and payment is not made by KanCare or your Health Insurance, you may be responsible for the charges. You may also be responsible for charged if you fail to inform the Health Department of Insurance coverage in a timely manner. The undersigned has read the above authorization and understands the same. I certify that the information provided is true and correct to the best of my knowledge for myself or the person named above for whom I am parent or legal guardian of and authorized to make medical decisions for.

If immunizations are not covered by your health insurance. These items are required to comply with federal regulations, to receive services through the Vaccine For Children program; a written statement, or explanantion of benefits claim from your Health insurance company stating immunizations are not covered. If we do not have a written statement prior to services the patient will be responsible for any portion that insurance will not cover. I consent for the inclusion of vaccines given as immunization data in the Kansas Immunization Registry for myself or the person named above for whom I am parent or legal guardian of and authorized to make medical decisions for.
It is your responsibility to verify that Riley County Health Department is an in-network provider for your insurance company. Charges will be the full price if Riley County is deemed a non-network provider after services are provided.

PRIVACY PRACTICES

All records of services rendered are considered confidential. I acknowledge that I have been offered a copy of the Riley County Health Department's Notice of Privacy Practices with the effective date of April 2019.

LABS / IMMUNIZATIONS

I have received information about the TB skin test. I had a chance to ask questions which were answered to my satisfaction. I agree to return in 48-72 hours to have the test read. I understand the risks and benefits of the TB skin test and request the test be given to me or the person named above for whom I am parent or legal guardian of and authorized to make medical decisions for.
I have been advised to wait for 15 minutes after vaccination at Riley County Health Department or outreach location.

DATA APPLICATION AND INTEGRATION SOLUTION FOR THE EARLY YEARS (DAISEY)

As part of the Kansas Department of Health and Environment Family Health Comprehensive System, we will enter your data collected within your family planning visits in an electronic system, Data Application and Integration Solution for the Early Years (DAISEY). The system is designed to keep your information secure. We will only use your information to track, evaluate, and improve reproductive health services you receive from us.

Information that will be entered in the system includes:

- Individually Identifiable Health information (Ex: name, gender, date of birth).
- Information about services you receive (Ex: health screening, education, home visits).
- Information about assessments you receive as part of a service (Ex: answers to questions about housing needs, tobacco use, prenatal care).

This notice is effective on the date below. Your signature acknowledges receipt of this notice but is not required. This notice will remain in effect until the organization destroys your information. You may ask to see your information at any time.

INTEGRATED REFERRAL AND INTAKE SYSTEM (IRIS)

By signing below I agree that my family/household members' information can be shared in IRIS with other service providers in my community's referral network who will also secure my information. All information is confidential and will only be shared for its intended purpose of providing wanted services to yourself and/or your family.

_____ _____

Patient Signature / Parent or Guardian | Date

_____ _____

Patient Name (printed) | Patient Date of Birth

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**.

Riley County Health Department

NOTICE OF PRIVACY PRACTICES

Effective Date: April 2019

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.

If you have any questions about this notice, please contact

The Privacy Officer
Heather Ritchey
2030 Tecumseh Road
Manhattan KS 66502
785-776-4779 – telephone
785-565-6565 – fax

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for your future care or treatment, and billing-related information. Such records are necessary for the healthcare provider to provide you with quality care and to comply with certain legal requirements.

We are committed to protecting the confidentiality of our records containing information about you. The notice applies to all records of your care created or received by the Riley County Health Department. Other healthcare providers from whom you obtain care and treatment may have different policies or notices regarding the use and disclosure of your health information created or received by that provider. Also, health plans in which you participate may have different policies or notices concerning information they receive about you.

This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to maintain the privacy of your health information; give you this notice of our legal duties and privacy practices and make a good faith effort to obtain your acknowledge of receipt of this notice; and follow the terms of notice that is currently in effect.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy your health information, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice. You will be asked to complete a written authorization form. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. We may require that you pay such a fee prior to receiving the requested copies.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Riley County Health Department will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request Amendment: If you believe that our records contain information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Riley County Health Department.

To request an amendment, you must complete a specific form providing information we need to process you request, including the reason that supports your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice.

We may deny your request for an amendment if you fail to complete the required form in its entirety. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information kept by or for the Riley County Health Department;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete

If your request is denied, you will be informed of the reason for denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law.

To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the cost 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 health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health 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. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this notice.

Right to Request Alternative Methods of Communication: 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.

To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice. We will not ask you the reason for your request. We will try to 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. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website, www.rileycountyks.gov/health

To obtain a paper copy of this notice, contact the person identified on the first page of this Notice.

COMPLAINTS: If you believe your rights to health information about you have been violated by the Riley County Health Department, you may file a complaint with the Riley County Health Department or the with Secretary of the Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave. S.W., Washington DC 20201. To file a complaint with the health department, contact the person identified on the first page of this Notice. All complaints must be submitted in writing.

How We May Use and Disclose Health Information about You without Your Specific Authorization: The following categories describe different ways that we are permitted to use and disclose health information without a specific authorization from you. If you desire to restrict our use of your health information for any of these purposes, you need to submit a request for restriction in the manner described above.

For Treatment: We may use information about you to provide you with medical treatment or services. We may disclose health information about you to provide you with medical treatment or services. We may disclose health information about you to nurses, technicians, or other personnel who are involved in taking care of you at the Riley County Health Department. Different departments of the Riley County Health Department also may share health information about you in order to coordinate the different things you need, such as prescriptions, lab work, and x-rays.

We also may disclose health information about you to people outside of the Riley County Health Department who may be involved in your medical care after you leave the Riley County Health Department, such as family members, friends, or others we use to provide services that are part of your care. We will give you an opportunity, however, to restrict such communications.

We may disclose health information about you to other health care providers who request such information for purposes of providing medical treatment to you.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at the Riley County Health Department may be billed to and payment may be collected from you, an insurance company, or other third party. For example, we may need to give your health plan information about treatment you received so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We also may provide information about you to other health care providers to assist them in obtaining payment for treatment and services provided to you by that provider. We may also provide information to a health plan for purposes of arranging payment for treatment and services provided to you.

For Health Care Operations: We may use and disclose information about you for our internal operations. These uses and disclosures are necessary to run the Riley County Health Department and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the health information we have with health information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific patients are.

We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or medical care at the Riley County Health Department. Unless you direct us to do otherwise, we may leave messages on your telephone answering machine identifying the Riley County Health Department and asking you to return our call. Unless we are specifically instructed by you otherwise in a particular circumstance, we will not disclose any health information to any persons other than you who answers your phone except to leave a message for you to return the call.

Surveys: We may use and disclose health information to contact you to assess your satisfaction with our services.

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

Health – Related Benefits and Services: We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you, or to provide you with promotional gifts of nominal value.

Business Associates: There are some services provided in our organization through contracts or arrangements with business associates. For example, we may contract with a copy service to

make copies of your health record. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we've asked them to do. To protect your health information, however, we require our business associates to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Research: Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process, but we may, however, disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the health information they review does not leave the Riley County Health Department. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the Riley County Health Department.

As Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health 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, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose health 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 or transplantation.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Employers: We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law. ***Health Oversight Activities:*** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

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

- In response to a court order, subpoena, warrant, summons or 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 Riley County Health Department; and
- In emergency circumstances to report a crime, the location of the crime or victims; or the identity, descriptions or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of the Riley County Health Department to funeral directors as necessary for them to carry out their duties.

National Security and Intelligence Activities: We may release health 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 health information about you to authorize federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates/Persons in Custody: If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Electronic Health Information: We participate in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.

Second, you may restrict access to **all** of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

Other Uses of Health Information: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. Of course, we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Changes to This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our facility and on our website. The notice will contain on the first page the effective date.

Acknowledgement: You will be asked to provide a written acknowledgement of your receipt of this Notice. We are required by law to make a good faith effort to provide you with our Notice and obtain such acknowledgement from you. However, your receipt of care and treatment from the Riley County Health Department is not conditioned upon your providing the written acknowledgement.