California State University
SAN MARCOS

College of Education,
Health & Human Services

Department of Speech-Language Pathology

California State University San Marcos 333 S. Twin Oaks Valley Road San Marcos, CA 92096-0001

Tel: 760.750.7374 **Fax:** 760.750.3353

CSUSM Department of Speech-Language Pathology Clinics Notice of Privacy Practices

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

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose information. We will not use or disclose your medical information for any purposes not listed below, without your specific written authorization.

FOR TREATMENT: We may use medical information about to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to other health care providers to assist them in treating you.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting accreditation. Certificates, licenses, and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment and health care operations, we may use and disclose medical information for the following purposes.

FACILITY DIRECTORY: Unless you notify us that you object, the following medical information about you will be places in our facility directories: your name; your location in our facility; your condition described in general terms.

NOTIFICATION: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medical information about you.

PUBLIC HEALTH ACTIVITIES: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect.

4. YOUR INDIVIDUAL RIGHTS

You have the Right to:

Look at or get copies of certain parts of your medical information

Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

Request we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. You may respond with a statement or disagreement that will be added to the information you want changed.

5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us.

ACKNOWLEDGEMENT

I have read and understand CSUSM's Notice of privacy practices. I understand can request a copy of this letter

Signature:_____Date:_____

PrintedName:_____Patient'sName_____