

WHITE OAK MANAGEMENT, INC.

PRIVACY NOTICE

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

Effective Date: April 14, 2003

White Oak Management, Inc. values you, our resident, and is committed to preserving the privacy and confidentiality of your health care information. This notice being provided to you will explain how we protect the confidentiality and privacy of your information, how and when your health information may be used or disclosed and your rights regarding your health care information.

OUR DUTY TO PROTECT YOUR HEALTH CARE INFORMATION

Privacy and confidentiality of your health information have always been a high priority within our facilities. The Health Insurance Portability and Accountability Act (HIPAA) creates a national standard of protection and privacy of your medical information and requires that we:

1. Maintain and protect your health information
2. Notify you of your legal duties and privacy practices
3. Follow our current Notice of Privacy Practices
4. Comply with certain objections you may have with regard to our use and disclosure of your health information as specified herein
5. Comply with requirements regarding your individual rights as specified herein
6. Obtain your written authorization to use or disclose your health information for occasions other than those listed herein or permitted under law

This Notice applies to certain health records pertaining to your protected health care information, both medical and financial records created or maintained by the facility. This Notice further outlines how we may use and give out information about you for payment, healthcare operations, treatment and other requirements as outlined by law. While records are the physical property of the facility, you have certain rights in obtaining, reviewing, amending and disclosing your medical information as outlined in this notice, unless otherwise prohibited or required by law. **Should you have questions regarding this Privacy Notice, the name, address and telephone number of the person or person(s) whom you should contact is listed on the last page of this document.**

WHO IS REQUIRED TO COMPLY

All facilities of White Oak Management, Inc. must comply. Within each facility, the following persons must comply with the terms of this notice:

- All facility employees
- Departments and Units within the facility
- Vendors or Independent Contractor who may have access to your protected health care information
- All corporate staff including, but not limited to consultants, directors, financial or other corporate staff who may have access to your protected health information
- Any independent health care professional who provides care for you and who is authorized by you
- Any student, intern or other trainee
- Any approved volunteer who assists you or provides personal services for you

In addition, each of the above may share medical information with each other for treatment, payment or health care operations. Each independent health care professional or contracted person who provides you with care and services has agreed to abide by this notice. However, the facility is not responsible for how each conducts his/her professional responsibilities. Your personal doctor or other independent health care professional may have different policies regarding privacy, confidentiality and disclosure of your medical information that is created and/or maintained in their office or locations.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We have limited right to use and/or disclose your health information. There are three categories allowed by law in which we can release information without your consent. The three categories are: Treatment, Payment, and Health Care Operations. A summary of each will be outlined below with an example of each to help you understand how we use your information.

Treatment: We may disclose your protected health information to those who are involved in providing medical care and treatment for you. We may disclose information to independent doctors and other independent health care personnel who are permitted to treat you. Nurses, Pharmacists, Therapists, Nursing Assistants, Activity, Social and Dietary Professionals, Students and Faculty who are participating in clinical training, may all share information with each other in order to better care for you and to coordinate care for you. For example, your protected health information may be shared with your Pharmacist who fills your prescriptions to evaluate for any drug interactions. Your Physician may share information with your Dietician to assure the appropriate diet for healing of any wound or fracture that you may have. Your Physician may need to share/obtain information from any laboratory studies to better treat your diabetic condition. We also may need to disclose health information about you to persons outside the facility who may be involved in your medical care before, during or after you leave here such as hospitals or medical specialists, that are part of your care. We may provide, without your consent, health information about you in connection with any transfer to assist

you in obtaining care elsewhere or to provide health information to others as required by law.

Payment: In order to obtain payment for your care and services here at the facility and/or care given by other providers, we may need to use and disclose health information about you for the purpose of billing you, your insurance company, health plan, Medicare or Medicaid or other third party. For example, we may need to provide Medicare your diagnosis, type of therapy given, or other health information about you in order for Medicare to render payment to you or the facility. Our disclosure of medical information for the purpose of obtaining payment for care and services rendered may also include giving information to your family members who are involved in your care, who help pay for your care, or who are insured on your policy.

Health Care Operations: We may use or disclose your protected health information to perform certain functions within our facility, to operate our facility and to ensure that you and others in our facility continue to receive quality care and services. We may disclose your health information to our staff (nurses, nursing assistants, physicians, consultants, therapists, etc.) for auditing, care planning, treatment, education and learning, evaluation of staff performance, assessing quality care and for recommendations to improve care. We may disclose limited health information for other functions within our operations. For example, we may take your photograph for medication identification purposes or we may use your name or birthday on bulletin boards or the facility newsletter. Photographs may be used for medication administration or by the Activity Department for display of individual or group activities. Your name may be placed on the wall beside your door so that your visitors and our staff may easily locate you in our facility. We maintain a facility directory and roster. Unless you object, your name, location in the facility and religious affiliation will be contained in the directory. Except for your religious affiliation, the information contained in the directory/roster is disclosed to persons who specifically ask for you by name.

A member of the clergy or chaplain may visit you without asking for you by name. If you choose not to be listed in the directory, then we may not be able to acknowledge that you are in the nursing home to your family, friends and clergy or delivery personnel. If you do not want your information to be included in the directory or if you want your information or disclosure of your information to be limited, please contact us in writing. The name, address and contact number of the person to whom you need to submit this request is listed on the last page of this notice.

Individuals Involved in your care: We may disclose your health information and financial information to you and/or your family members involved in your care. If you are unable to consent or object, we may disclose your health information to your family or friends who are the ones most closely involved in your care. In an emergency or disaster situation, limited information considered in your best interest may be disclosed to others involved in your care. If you want uses and disclosures of your health information to individuals in your care to be limited in any way, please contact us in writing. The name, address, and

telephone number of the person to whom you need to submit this request is listed on the last page of this notice.

Treatment alternatives, health-related benefits and services: We may use or disclose your protected health information for purposes of contacting you to inform you of different ways of caring for you and/or to inform you of health-related benefits and services that may be of interest to you. For example, we may notify you of a newly released medication or treatment, which may benefit you.

Fund-raising Activities: Your protected health information will not be shared with individuals or organizations for general fund-raising activities. We may share information about you with individuals or organizations that are involved in fund-raising activities by or for the benefit of the facility or the facility's activity department. We would only release contact information, such as your name and room number. If you do not want the facility to release contact information, you must submit in writing to the person listed on the last page of this notice.

Research: Research that would disclose identifying data about you must not be disclosed unless we have your written authorization. Your authorization is not required for research that does not identify you. Research may be conducted or disclosed only after all personal identifiers have been removed. An example of this would be: a comparison study of all resident receiving one type of medication for memory utilizing success, based upon a self-performance study before and after the initiation of the medication.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION:

You may give us written authorization to use and disclose your health information for any purpose. You may also revoke your authorization in writing at any time or to stop future uses or disclosures of your information except to the extent that we have already taken an action relying upon your authorization. Unless you give us a written authorization, we will not use or disclose your health information for any reason except those allowed by law and described in this notice.

USE AND DISCLOSURES OF INFORMATION THAT DO NOT REQUIRE YOUR AUTHORIZATION:

State and Federal laws or regulations either require or permit us to use or disclose your protected health information without your authorization. The uses or disclosures that we may make without your authorization include:

1. ***When Required by Law:*** We may use and disclose your protected health information when laws require that we report abuse, neglect or domestic violence, or adverse reactions to medications or injury from a health care product or in response to a court order, grand jury demand, subpoena or search warrant, a death or injury believed to be a result of criminal conduct or any criminal conduct believed to have occurred.

2. ***For Public Health Activities for the Purpose of Preventing or Controlling Disease, Injury or Disability:*** We may disclose your protected health information to public health authorities. For example, we may be required to collect information about diseases or injuries (i.e., your exposure to a disease or your risk for spreading or contracting a communicable disease or condition, product recalls or to report vital statistics (deaths) to the public health authority.
3. ***To Prevent 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 and limited to the information needed.
4. ***For Health Oversight Activities:*** We may use and disclose your protected health information to health and oversight agencies such as the State/ local Ombudsman Program, Protection and Advocacy Agency and to the other agencies responsible for inspecting, auditing, investigating and surveying our facility. The functions of these agencies are to assure compliance with local, state, federal laws and regulations. Some professional licensing boards, such as licensing boards for nurses and physicians may review your records when investigating a specific incident.
5. ***To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks:*** We may disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We may also disclose your health information to a funeral director for the purpose of carrying out your wishes and/or for the funeral director to perform his/her necessary duties. If you are an organ or body donor, we are required to disclose to the organization that will carry out your wishes.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:

You have the following rights concerning the use or disclosure of your protected health information that we maintain:

1. ***To request restrictions on use and disclosures of your protected health information:*** You have the right to request that we limit how we use or disclose your protected health information unless law requires the disclosure.

Should you wish a restriction placed on the use and disclosure of your protected health information, you must submit such request in writing (note: you may submit such request using our "Request to Restrict the Use and Disclosure of Protected Health Information" form which can be obtained from the Admissions Office). You must tell us what information you want us to limit, whether you want to limit our use, or disclosure or both; and to whom you want the limits to apply (i.e., disclosure to your spouse). The name, address and telephone number of the person to whom you need to submit this request is listed on the last page of this notice.

We are not required to honor your request to restrict use or disclosure of your information within the nursing facility except with regard to psychotherapy notes. However, should we agree we will comply with your request. We will not release such information unless the information is needed to provide emergency care or treatment to you. Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement.

2. ***The Right to Inspect and Copy your Medical and Billing Records:*** You will have the right to inspect and copy your medical and billing records that we use to make decisions about your care and services. In order to inspect and/or copy your health information, you must submit a request to access your medical record. The name, address and telephone number of the person to whom you need to submit this request is listed on the last page of this notice. If you are a current resident, you or your representative have a right to view your record within 24 (twenty-four) hour's notice, excluding weekends and holidays; or to receive a copy of your records upon notice and 48 (forty-eight) hours, excluding weekends and holidays.

If you are no longer a resident at the time of your request to copy your record, the facility has thirty days to respond to your request if your records are on-site and 60 days if the records are not on-site. An additional 30 days may be allowed upon appropriate notice and reason for the needed extension.

If you are the resident's representative, you may be asked to show authentication of your right to receive the record on behalf of the resident. If you the resident, or appropriate representative(s) agree, we may provide you with a summary or explanation of the information instead of providing you with copies of all the information. Before providing you with such a summary or copy of the record, you will be given an explanation of the charges that are to be incurred with an expectation of payment prior to the preparation of summary or copying of the chart.

3. ***The Right to Amend or Correct Your Health Information:*** You have the right to request that your health information be amended or corrected if you have reason to believe that certain information is incorrect. You have the right to make such requests of us for as long as we maintain/retain your protected health information. Your request must be submitted to us in writing and you must submit a reason for wishing to amend your record. The name, address and telephone number of the person to whom you need to submit this request is listed on the last page of this notice.

We may be unable to comply with your request for an amendment to the record if you fail to submit the request in writing, or if you fail to include a reason for the amendment. If another provider other than our facility created the document which you wish to amend, or if the provider is no longer available to review your request or make the amendment, then your request may be denied. We cannot amend the record if the information is not maintained as part of our record, or if it is not part of the information which you would be permitted to inspect and copy, and/or the information is already accurate.

We must respond to your request for an amendment within 60 days of receiving the written request. An additional 30 days may be allowed upon appropriate notice and reason for the needed extension. If we approve your request, we will make such amendments or corrections and notify those with a need to know of such amendments or corrections.

If we are unable to comply with your request, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response attached to any future disclosure of the information in question. You may submit your amendment request(s) on our "Request for Amendment / Correction of Protected Health Information" form. Copies of these forms are available in the Admissions office.

4. ***The Right to Request Confidential or Alternative Communication:*** You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. We will agree to your request as long as it is reasonably easy for us to do so. You are not required to reveal, nor will we ask the reason for, your request. To request confidential communications you must: notify us in writing, indicate what information you wish to limit, indicate whether or not you wish to limit or restrict our use or disclosure of such information and identify to whom the restrictions apply (i.e., which family member(s), agency, etc).

The name, address and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your request on our "Request for Restriction of Confidential Communications" form. Copies of these forms are available in the Admissions office.

5. ***The Right to Request an Accounting of Disclosures of Protected Health Information:*** You have the right to request that we provide you with a listing of when, to whom, for what purpose, and what content of your protected health information we have released over a specified period of time. The accounting will not include any information we have made for the purpose of treatment, payment or health care operations or information released to you, or your representative or the facility directory, disclosures made for national security purposes, or any releases pursuant to your authorization.

To request this accounting, you must submit in writing your request and indicate the time period for which you wish the information (i.e., May 1, 2003 through June 1, 2003) and in what form you want this information. Your request may not include releases for more than six (6) years nor include releases prior to April 14, 2003. We will respond to your request within sixty (60) days of receipt of the written request. Should additional time be needed to reply, you will be notified of such extension. However, in no case will such extension exceed thirty (30) days. The first accounting you receive during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The name, address, and telephone number of the person to whom you may file your request is listed on the last page of this document. You may submit your request on our "Request for and Account of Disclosures of Protected Health Information" form. Copies of this form are available in the Admission's office.

6. ***The Right to Receive a Paper Copy of this Notice:*** You have the right to receive a paper copy of this notice or any revised notice. You may request an electronic copy of this notice, but you are entitled to a paper copy. This notice will be posted in a public area in the facility and on our web site.

Our website for viewing our privacy notice is www.whiteoakmanor.com

To obtain a paper copy of this notice, contact our Admissions Coordinator.

7. ***The Right to Revoke:*** Uses and disclosures of protected health information not included in this notice will be made only with your authorization or as allowed or required by law. If you have authorized use or disclosure of health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will not disclose any further health information about you that you had authorized. You understand that we are unable to withdraw any disclosures prior to the revocation.
8. ***Privacy Notice Updates or Revisions:*** We reserve the right to change, update, or revise this Privacy 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 in a public area in the facility. You may receive a copy upon request.

HOW TO FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES:

If you have reason to believe that we have violated your privacy right, or you disagree with a decision we made about your privacy rights, you have the right to file a complaint with the Facility Privacy Representative, the Corporate Privacy Representative, the Compliance Director, the compliance hotline or the U.S. Department of Health and Human Services located at 200 Independence Avenue, S.W., Washington, D.C. 20201, (Telephone No. 202-619-0257). You may submit your complaint on our Grievance form.

Complaints may be made without fear of retaliation.

The name, address, and telephone number of the person to whom you may file your complaint is listed below:

Facility Privacy Representative:

Mary Bolt
130 E. Main Street
Spartanburg, SC 29306

864-573-0106 ext. 256

For Our Residents

Notice of Privacy Practices



White Oak Management, Inc.