

**Summit County Ambulance/Park City
Fire Service District,
dba Park City Fire District,
North Summit Ambulance, and South
Summit Ambulance:
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.

Summit County Ambulance/Park City Fire Service District, dba Park City Fire District, North Summit Ambulance, and South Summit Ambulance is required by law to maintain the privacy of your health information and to provide you with this notice of its legal duties and privacy practices with respect to your protected health information. We are required to comply with the rights and standards set out in this Notice. We are also required to notify you and all affected individuals following a breach of any unsecured protected health information ("PHI").

Here are examples of the ways that we may use or disclose your PHI:

For treatment. To try to provide you with quality care, we keep records of office visits, procedures and other care we provide you. We may also request your PHI from other doctors, such as your primary care doctor, to ensure that our care meets your needs. Sometimes, we may also provide your PHI to other medical providers, if we believe good care requires us to consult with or involve other physicians, specialists or laboratories.

For payment. We use your PHI to bill and collect for the medical services we provide. For example, we will use your PHI to verify your insurance eligibility or coverage and to submit bills and claims to your insurer or other payers, such as Medicare. We may also contact payers to give them notice or get prior approval for medical services we intend to provide to you.

For health care operations. We will use your PHI for general health care operations, for

example, assessing and improving our quality of care, training our staff, enhancing customer services, managing our costs, responding to audits, or coordinating our care with other medical providers.

We may use or disclose your PHI for other purposes, including:

- **Alternative treatments.** We may use your PHI to recommend or inform you of additional or alternative treatments that we believe may benefit you.
- **Research.** We may use your PHI to notify others involved in medical research that you may want to participate in clinical trials of new medications or devices. You will be given a separate right to consent to participate or refuse to participate in any such research.
- **Family, friends, and caregivers.** Unless you tell us not to, we may share your PHI, when appropriate, with family members, friends or caregivers, or those who pay for, or help you pay for, your medical services.
- **Business associates.** We may share your PHI with others who help us run our medical practice or work on our behalf. They must follow our privacy practices and have the same duty as we do to keep your PHI confidential.
- **Uses or disclosure required by law.** We are required by law to make certain disclosures without your authorization, such as reporting communicable diseases, work-related illnesses and injuries, disclosures to protect victims of abuse, exploitation or neglect, reporting required by medical examiners, law enforcement or courts, or for organ or tissue donation.

All other uses or disclosures of your PHI not set out in this Notice require your separate signed authorization. You can revoke your authorization at any time by giving us a signed statement. Your revocation will not apply, however, to uses or disclosures we made prior to receiving your revocation.

YOUR INDIVIDUAL RIGHTS. Under federal law, you have the following rights:

- **The right to request restrictions on how we use or share your PHI.** We will seriously consider any such request, but we are not required to agree to it -- except that we must comply if you request us not to disclose your PHI to your health insurer if the PHI pertains solely to an item or service for which you (or another on your behalf) have paid us in full, and such disclosure is not otherwise required by law.
- **The right to receive your PHI from us** by alternative means or at alternative locations.
- **The right to inspect your PHI** (at no charge).
- **The right to get a copy of any or all of your PHI.** The first request for copies will be complimentary. You may receive the PHI in a paper copy, but you may also request to receive your PHI in a different format, such electronically in an email or PDF, and we will comply with your request if we reasonably can.
- **The right to amend or add to your PHI.**
- **The right to receive an accounting of all the disclosures we have made of your PHI** for any period of time within the 6 years prior to your request. Your right to an accounting does not include disclosures of your PHI we have made for purposes of treatment, payment, or operations. The first accounting will be complimentary.
- **The right to receive a paper copy of this Notice of Privacy Practices,** even if you have already received an electronic version.
- **You have the right to complain if you believe your privacy rights have been violated.** You will not be retaliated against if you complain. To file a complaint, you may contact our Privacy Officer:

Privacy Officer
 Park City Fire Service District
 736 West Bitner Road
 PO Box 980010
 Park City, UT 84098-0010
 Tel: (435) 940-2511
 Fax: (435) 940-2451

or the Secretary of Health and Human Services at the following address:

Secretary of Health & Human Services
 Region VIII Office of Civil Rights
 US Department of Health & Human Services
 1961 Stout Street, Room 1185 FOB
 Denver, CO 80294-3538
 Telephone: (303) 844-2024
 Fax: (303) 844-2025
 TDD: (303) 844-3439

This Notice is effective April 14, 2003 and has been revised on October 16, 2013. We retain the right to amend this Notice in the future, after which you will be given a new Notice at your next EMS encounter and asked to acknowledge your receipt of it. Any new or amended Notice of Privacy Practices will apply to all the medical and protected health information that we maintain or have in our records.

I ACKNOWLEDGE THAT I RECEIVED A COPY OF THIS NOTICE OF PRIVACY PRACTICES:

Signature of Patient or Patient Representative

Date

Patient or Representative refused to sign
 Patient unable to sign because of emergency circumstances
 Other circumstances prohibited obtaining consent – Explain:
