

**Mary Immaculate Health/Care Services**

172 Lawrence Street  
Lawrence, MA 01840

**SUMMARY**

**NOTICE OF PRIVACY PRACTICES**

Effective date : 4/14/03

**THIS SUMMARY 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.**

This notice highlights how we use and disclose your protected health information or **PHI**. It is NOT the complete NOTICE of PRIVACY PRACTICES. We have created this short form summary notice to provide us with a way to be sure you have reviewed our Notice of Privacy Practices, have had the opportunity to discuss the Notice of Privacy Practices with a staff member and to provide us with a document that we can include in your healthcare record.

The facility reserves the right to make changes and will post the Notice of Privacy Practices in a clear and prominent location in our facility for your review.

**THIS NOTICE APPLIES TO THE FOLLOWING ENTITIES AND INDIVIDUALS  
(Review the full Notice of Privacy Practices for more specific listing)**

1. The facilities' healthcare professionals, staff and personnel.
2. Any member of a volunteer group working at the facility.

**HOW WE MAY USE AND DISCLOSE YOUR INFORMATION**

We are legally required to protect the privacy of information that is related to your health care that can be used to identify you. This information is called your "Protected Health Information". During the normal business operations of the facility we use your information to provide you and others with the highest quality care. We may disclose your PHI for the following reasons; (in some instances, you may say NO to a disclosure).

- \* *Treatment (including emergencies);*
- \* *General operations*
- \* *Public Health initiatives*
- \* *Federal, State or Local Law enforcement*
- \* *Reminders or Appointments*
- \* *Organ donation*
- \* *Business Associates (people who provide us services for you)*
- \* *Federal, State or health oversight legal or administrative issues*
- \* *Correctional facilities*
- \* *Billing and payment*
- \* *Worker compensation*
- \* *To protect your welfare*
- \* *Government functions*
- \* *Research*
- \* *Fundraising*

**Specifically you may object to the following use or disclosures;**

- Facility directory
- Notification of family friends or others.

All other disclosures if they not listed in the Notice of Privacy Practices will require us to ask for your written authorization.

**RIGHTS YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION.**  
(Review the rights we have to deny a request under certain situations in the full document)

- Right to inspect and copy your medical information.
- Right to amend and change your record.
- Right to an accounting of disclosure not authorized by you.
- Right to request restriction on what we disclose about you.
- Right to choose how we communicate with you about medical matters.
- Right to complain if you think your rights have been violated.

**COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with the facility privacy officer or with the Secretary of the Department of Health and Human Services ("HHS") at 200 Independence Avenue, S.W., Washington, D.C. 20201 or by sending HHS and e-mail at [HHS.Mail@hhs.gov](mailto:HHS.Mail@hhs.gov).

**YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT**

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**WRITTEN ACKNOWLEDGEMENT OF RECIEPT**

By signing below, I acknowledge that I have reviewed the full version of the Notice of Privacy Practice along with the Summary of the Notice of Privacy Practices for the facility and that I have gone over the information with a member of the facility staff and I have been given the opportunity to ask questions. I also understand that I have a right to request and receive the full length copy of the Notice of Privacy Practices for myself. I further understand that a copy of this notice is also posted in a clear and prominent location in the facility.

By: \_\_\_\_\_  
(Client or responsible party)

Date: \_\_\_\_\_

By: \_\_\_\_\_  
(staff member in attendance)

Date: \_\_\_\_\_

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I \_\_\_\_\_ (staff member) hereby attest that I tried in good faith to obtain a written acknowledgement of receipt of the Notice of Privacy Practices by Mr./Mrs. \_\_\_\_\_ but was unable to do so. The reason it was not obtained is;  
\_\_\_\_\_  
\_\_\_\_\_