Student Outreach Clinic

University of Nevada, Reno School of Medicine

Notice of Privacy Practices

(Effective March 28, 2025)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your protected health information (PHI):

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. We may use and disclose PHI without your specific authorization for treatment, payment, operations and other specific purposes. It also includes contacting you for appointment reminders and follow-up care. All other uses and disclosures require your specific authorization.

We have the right to change our notice of privacy practices, and we will apply the change to your entire PHI, including information obtained prior to the change.

We post copies of the current Notice in the clinic and on our Internet site, and we will provide a copy to you upon request.

Your health information rights:

Right to inspect and copy:

- You have the right to inspect and obtain a paper or electronic copy of health information that may be used to make decisions about your care. Usually, this includes medical records but may not include some mental health information. We may charge a fee of $.60 per page and the actual cost of postage, pursuant to NRS 629.061, to cover the costs of providing your health information records to you. You are not entitled to access, or to obtain a copy of, psychotherapy notes and/or information compiled for legal proceedings.

Right to amend:

- If you believe that health information that the Student Outreach Clinic has on file about you is incorrect or incomplete, you may ask us to amend the health information. To request an amendment, you must send an appropriate written request to the Student Outreach Clinic that will be reviewed by the appropriate personnel. In addition, you must provide a reason that supports your request to amend. The Student Outreach Clinic may only amend information that we created

or that was created on our behalf. If your health information is accurate and complete, or if the information was not created by the Student Outreach Clinic, we may deny your request to amend. If we deny your request, we will reply to you in writing with our reasons for doing so. Even if we deny your request to amend, you have the right to submit a written addendum. Addendums may not exceed 250 words for each item or statement in your record which you believe is incomplete or inaccurate.

Right to an accounting of disclosures:

- You have the right to request an "accounting of disclosures" which is a list describing how we have shared your health information with outside parties. This accounting is a list of the disclosures we made of your health information for purposes other than treatment, payment, health care operations, and certain other purposes consistent with law. You may request an accounting of disclosures for up to six (6) years before the date of your request.

Right to request restrictions:

- You have the right to request restrictions on certain uses or disclosures of your health information. Requests for restrictions must be in writing to the Student Outreach Clinic. In most cases, we are not required to agree to your requested restriction. However, if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or comply with the law. If we do not agree to your request, we will reply to you in writing with the reason.

Right to opt-out of fundraising communications:

- As part of fundraising activities, the University of Nevada Reno School of Medicine or its affiliates may contact you to make you aware of giving opportunities for the clinic. You have the right to opt-out of receiving fundraising communications. Fundraising communications will include information about how you can opt out from receiving future fundraising communication if you wish.

Right to request confidential communications:

- You have the right to request that we communicate with you about your health information or medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, rather than at your home. We will not ask you the reason for your request. We will work to accommodate all reasonable requests. Your request must be in writing to the Student Outreach Clinic and specify how and where you wish to be contacted.

Right to be notified of a breach:

- The Student Outreach Clinic is committed to safeguarding your health information and proactively works to prevent health information breaches from occurring. However, if a breach of unsecured health information occurs, we will notify you in accordance with any applicable state and federal laws.

Right to a copy of this notice:

- You have the right to a copy of this Notice. It is on our internet home page at: **www.med.unr.edu/student-outreach-clinic**.

How we may use and disclose health information about you:

The following sections describe different ways that we use and disclose your health information:

For treatment:

- We may use health information to provide you with medical treatment or services. We may use and share health information about you with physicians, residents, nurses, technicians, medical students, or other clinic personnel involved in your care. We may also disclose your health information to providers not affiliated with the Student Outreach Clinic to facilitate care or treatment they provide you or for purposes of referral.

For health care operations:

- We may use and disclose health care information for health care operations. This includes functions necessary to run the clinic or assure that all patients receive quality care, and includes many support functions such as appointment scheduling. We may also share your information with affiliated health care providers so that they may jointly perform certain business operations along with the clinic. We may aggregate patient health information to decide, for example, what additional services the clinic should offer, what services are not needed, and whether certain new treatments are effective. We may share information with doctors, residents, nurses, technicians, medical students, community health workers, clerks and other personnel for quality assurance and educational purposes. We may also compare the health information we have with other clinics to see where we can improve the care and services we offer. Additionally, we may contact you with regard to patient satisfaction surveys.

Associates:

- The clinic may contract with outside entities that perform business services for us, such as information technology, software and medication/vaccine programs. In certain circumstances, we may need to share your health information with an associate so it can perform a service on our behalf.

Appointment reminders and other communication:

- We may use and disclose health information to contact you as a reminder that you have an appointment for care at the clinic. We will communicate with you using the information (such as phone number, email address) that you provide. Unless you notify us to the contrary, we may use the contact information you provide to communicate general information about your care such as appointment location, date and time.

Treatment alternatives:

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

Health-related benefits or services:

- We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.

Individuals involved in your care:

- We may release health information about you to a family member or friend who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request to the contrary, made by you and accepted by the clinic, we may also notify a family member, personal representative, guardian or other person responsible for your care about your location and general condition. This does NOT apply to patients receiving treatment for certain conditions, such as sensitive services, or substance/alcohol abuse. In addition, we may disclose health information about you to an organization assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status and location.

Fundraising activities:

- Consistent with applicable state and federal laws, we may provide limited information such as your contact information, provider name and dates of care to the University of Nevada Reno Foundation and its affiliates to conduct fundraising activities for the advancement of care and research on behalf of the University of Nevada Reno School of Medicine.

To prevent a serious threat to health or safety:

- We may use and disclose certain information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of others. However, any such disclosure will only be to someone reasonably able to prevent or respond to the threat, such as law enforcement, or notice to a potential victim. For example, we may need to disclose information to law enforcement when a patient reveals intent to participate, or participation, in a violent crime.

Special situations that do not require your authorization:

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 activities:

We may disclose health information about for public health activities. These activities include, but are not limited to the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report reactions to medications or problems with products;
- To report the abuse or neglect of children, elders, and dependent adults;
- To notify you of the recall of products you 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 you have been the victim of abuse, neglect or domestic violence; we will only make this disclosure when required or authorized by law;
- To notify appropriate state registries when you seek treatment at the clinic for certain diseases or conditions.

Health oversight activities:

- We may disclose information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system and government programs.

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, legally enforceable discovery request, or other lawful process by someone else involved in the dispute.

Law enforcement:

We may release health information at the request of law enforcement officials in limited circumstances to include:

- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain limited circumstances, the victim is unable to consent;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the clinic;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identify, description 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 to identify a deceased person or to determine the cause of death. We may also release health information about patients of the clinic to funeral directors as necessary to carry out their duties with respect to the deceased.

Military and Veterans:

- If you are an active 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.

National Security and Intelligence Activities:

- Upon receipt of a request, we may release health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We will only provide this information after our Privacy Officer, in consultation with our legal counsel, has validated the request, reviewed and approved our response.

Other uses or disclosures required by law:

- We may also use or disclose health information about you when required to do so by federal, state or local laws not specifically mentioned in this Notice.

Situations that require your authorization

For uses and disclosures not generally described above, we must obtain your authorization. For example, the following uses and disclosures will be made only with your authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of Protected Health Information (PHI);
- Most uses and disclosures of psychotherapy notes; and
- Other uses and disclosures not described in this Notice.

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 activities covered by the authorization, except if we have already acted in reliance on your permission. We are unable to take back any disclosures we have already made in reliance upon your prior authorization.

Acknowledgment of Receipt and Expiration of Agreement

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices, effective **March 28, 2025**. Please signify your acknowledgement with your signature beneath the following statement:

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that University of Nevada, Reno School of Medicine, the physicians, the nurses, medical students, residents and other University of Nevada, Reno School of Medicine staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern University of Nevada, Reno School of Medicine's operations and responsibilities. I further acknowledge that I understand that if I have any questions regarding this Notice, or wish to file a complaint, I may contact the University of Nevada, Reno School of Medicine Privacy Officer listed below. I also understand that no other staff member, physician or nurse or any other person is authorized to accept a request to exercise my rights but the privacy officer for University of Nevada, Reno School of Medicine.

Expiration of Agreement: This acknowledgement will remain in effect for 12 months from the date of my signature. After this period, the terms of this Notice will expire unless updated or renewed.

Privacy Officer
University of Nevada, Reno School of Medicine
1664 N. Virginia Street, Mail Stop: MS0346
Reno, Nevada 89557
Tel (775) 784-6214

Signature: _____ Date: _____

Printed Name: _____

If patient is a minor:

Signature of Patient representative: _____ Date: _____

Printed Name: _____

Relationship to patient: _____

Revocation of Consent for Use and Disclosure of Protected Health Information (PHI)

Overview of Revocation Process

You have the right to revoke any consent or authorization you have previously given regarding the use or disclosure of your Protected Health Information (PHI) under the Notice of Privacy Practices.

- **How to Revoke Consent:** To revoke your consent, you must submit a written request to the University of Nevada, Reno School of Medicine Privacy Officer. The request should clearly state that you are revoking consent for the use or disclosure of your PHI.
- **Impact of Revocation:** Revoking your consent will not affect any actions that have already been taken based on your previous consent.
- **Acknowledgement of Revocation:** Once your revocation is received, we will provide written acknowledgment. Processing may take up to 5-10 business days.

Instructions for Submitting Your Revocation

Please complete the form below to revoke your consent. After filling it out, submit it to the Privacy Officer via one of the following methods:

Mail: Privacy Officer

University of Nevada, Reno School of Medicine
1664 N. Virginia Street, Mail Stop: MS1332
Reno, Nevada 89557

Email: compliance@med.unr.edu

Revocation of Consent Form

To: University of Nevada, Reno School of Medicine

Privacy Officer
1664 N. Virginia Street, Mail Stop: MS1332
Reno, Nevada 89557

Date: _____

Patient Information:

Full Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Subject: Revocation of Consent for Use and Disclosure of Protected Health Information

Dear Privacy Officer,

I, the undersigned, revoke my consent for use and disclosure of my Protected Health Information (PHI) as described in the Notice of Privacy Practices provided by the University of Nevada, Reno School of Medicine.

Specifically, I revoke my consent for use and/or disclosure of my health information for (specify details or leave blank for general revocation):

_____

_____

Please confirm receipt of this revocation. I may contact the Privacy Officer with any questions.

Sincerely,

_____ _____

Signature of Patient or Legal Guardian Printed Name of Patient or Legal Guardian

_____

Relationship to Patient (if applicable)