Florida HEALTH
Seminole

Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

APPLICATION PACKET

Client and Website Only

For questions please call:	
Regional Coordinator:	Arlene Cardona
Counties Served by Region:	Seminole, Lake
Phone: 407-665-3185	Confidential Fax: 407-665-3302

Please use checklist below to ensure all paperwork is completed and returned with this coversheet to:

Seminole Regional FBCCEDP Office via confidential fax or mail to:

Florida Department of Health Seminole County
Florida Breast and Cervical Cancer Early Detection Program
400 W. Airport Blvd.
Sanford, FL 32773

CLIENT CHECKLIST	
☐	Annual Applicant Agreement
☐	Financial Eligibility Form
☐	Client Enrollment Form
☐	Initiation of Services *(for County Health Departments only)*
☐	Authorization to Disclose Confidential Information
☐	Your Provider's Mammogram Order

Florida HEALTH
Seminole

Florida Breast and Cervical Cancer Early Detection Program

Client Enrollment Form

LAST NAME:	FIRST NAME:	MAIDEN NAME:	DATE OF BIRTH:

1. APPLICANT INFORMATION (Please complete each section of this application.)

CONTACT INFORMATION

STREET ADDRESS:	
STREET ADDRESS:	
CITY & ZIP CODE:	
EMAIL ADDRESS:	
PRIMARY PHONE:	
ALTERNATE PHONE:	

BEST TIME TO REACH YOU:

☐ A.M. ☐ P.M. ☐ Anytime

☐ Is it okay to leave a message?

PREFERRED APPT. DAY/TIME:

HOW DID YOU HEAR ABOUT THIS PROGRAM? (Check all that apply.)

☐ American Cancer Society
☐ Brochure
☐ County Health Department
☐ Community/Health Fair event
☐ Family/Friend
☐ Internet/Website
☐ Private Medical Office
☐ Newspaper
☐ Federally Qualified Health Center
☐ Other
☐ Postcard
☐ Television
☐ Radio
☐ Social Media
☐ Educational Session
☐ Bus wraps/benches/signs
☐ Billboards

Name of Community Health Clinic:

SCREENING STATUS (Check only one response.)

☒ Initial (first time in program) ☐ Rescreen (previously in program)

☐ Short-term interval follow-up or repeat exam (less than 300 days from last screening)

Do you have health insurance? ☐ Yes ☒ No

If yes, what is the name of your insurance? N/A

DEMOGRAPHIC INFORMATION

RESIDENTIAL AND CITIZENSHIP STATUS (Check all that apply.)

☐ Florida resident ☐ U.S. Citizen ☐ Citizen in lawful status ☐ Other

ETHNICITY AND RACE IDENTIFICATION (Check all that apply.)

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

RACIAL IDENTITY

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

SPOKEN LANGUAGE(S)

Primary language spoken:

Additional language(s) spoken:

Language preference to receive email:

☐ English ☐ Spanish ☐ Haitian Creole

BARRIERS

Are there any barriers that would prevent you from keeping your appointments?

☐ Transportation ☐ Language ☐ Disabilities

☐ Other (List) _____

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#:

LAST NAME: | FIRST NAME: | MAIDEN NAME: | DATE OF BIRTH:

2. HEALTH HISTORY

GENERAL HEALTH STATUS (Check all that apply)

- ☐ Diabetes
- ☐ Pre-Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol

HEIGHT (in.): ☐ WEIGHT (lbs.): ☐

TOBACCO USE (includes vaping, e-cigarettes, and similar products) (Check all that apply)

- ☐ Daily
- ☐ Some days
- ☐ Never/not at all
- ☐ Declined to answer
- ☐ Were you given a referral to Quitline?
- ☐ Declined referral
- ☐ I am interested in quitting.

BREAST EXAM BACKGROUND (Check all that apply)

- ☐ Do you have breast implants?
- ☐ Are you currently experiencing any issues with your breasts? Explain.

- ☐ Have you ever been diagnosed with breast cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last mammogram before enrolling in this program? (Month/Year)

☐ ☐ None ☐ Unsured (2+ years)

Where was your last mammogram done? (Provider, City, State)

CERVICAL EXAM BACKGROUND (Check all that apply)

- ☐ Are you currently experiencing any issues with your cervix? Explain.

- ☐ Have you ever been told by a doctor you have invasive cervical cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last Pap test before enrolling in this program? (Month/Year)

☐ ☐ None ☐ Unsured (10+ years)

Where was your last Pap test done? (Provider, City, State)

- ☐ Have you ever had a hysterectomy? Specify whether partial or full.
- ☐ Partial hysterectomy (I still have a cervix)
- ☐ Full hysterectomy (no cervix)

What was the reason for the hysterectomy?

FAMILY HISTORY

Has anyone in your family, such as your mother, sister, brother, or father, been diagnosed with breast cancer? If yes, which relative?

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#:

Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

The Annual Applicant Agreement (AAA) is used to obtain authorization and information from eligible women enrolled in the Florida Breast and Cervical Cancer Early Detection Program (FBCC). The FBCC will collect participant Protected Health Information (PHI) and Personally Identifiable Information (PII) that is required to provide patient services.

Please read each statement below and agree by signing at the bottom of the document.

As an FBCC applicant, I declare that:

1. I am a Florida resident and I want to become a client of the FBCC, and I may withdraw at any time.
2. My net family annual income is at or below 200% of the Federal Poverty Level (FPL) and I have no health insurance that pays for breast and cervical cancer screening exams.
3. I will no longer be eligible for FBCC if my income changes to above 200% of the FPL.
4. I will call FBCC Once I obtain health insurance and give them the name of the health insurance company, policy number and effective date. If my health insurance covers breast and cervical cancer screenings my screenings will no longer be paid for by FBCC.
5. I will disclose any breast or cervical screening services that may impact my eligibility of enrollment in FBCC.
6. I may have a share of cost for some services.
7. I will use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test).
8. **I agree to complete any follow-up tests within 60 days. If I fail to meet these guidelines, I may be responsible for partial or full cost of all services.**
9. I will allow an exchange and release of my medical information between my health care providers, the FBCC, the Florida Department of Health's Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination and procedure results, even if they were not paid by FBCC.
10. I agree to receive home phone, cellphone, email or postal mail contact from FBCC and the Department of Children and Families (DCF) Medicaid Program about my health care.
11. I understand that the FBCC is a breast and cervical cancer **screening** program, not a cancer treatment program.
12. If I am diagnosed with breast or cervical cancer as a result of FBCC screening, I will be referred to DCF Medicaid Program which will determine if I am eligible for Medicaid benefits to cover treatment cost. I can reapply to FBCC for screenings once treatment is completed.
13. This agreement is for **one** year unless my program eligibility changes. If my eligibility status changes or this agreement expires, I may be responsible for services provided during my FBCC ineligible period.
14. **As authorized by federal law, Title 5 U.S. Code section 552a, collection of social security numbers by the Florida Department of Health for the FBCC may be necessary in order to apply for and receive Medicaid benefits.**

If you have any questions, contact your Regional Coordinator at the local Regional FBCC office:

Local Regional FBCC: SEMINOLE Phone (407)665-3185

Client Signature _____ Date _____

Printed Name _____ Date of Birth _____

Client Email Address: _____

Florida Breast and Cervical Cancer Early Detection Program (FBCC)

FINANCIAL ELIGIBILITY

Client Name:_____ **Date of Birth:**_____ **ID#**_____

1. Do you have Medicaid? ☐ YES ☐ NO **OR** Do you have Medicare? ☐ YES ☐ NO
2. Do you have any form of health insurance? ☐ YES ☐ NO Name of insurance _____
3. **Number of people in your Household.**_____(include yourself, spouse or civil union partner, and dependent children)
4. **Net Household Income (After Taxes): $**_____Month **OR $**_____Year

Family Size	2025 DOH Scale Monthly Income	2025 DOH Scale Yearly Income
1	$2,608.25	$31,299.00
2	$3,524.91	$42,299.00
3	$4,441.58	$53,299.00
4	$5,358.25	$64,299.00
5	$6,274.91	$75,299.00
6	$7,191.58	$86,299.00
7	$8,108.25	$97,299.00
8	$9,024.91	$108,299.00
9	$9,941.58	$119,299.00
10	$10,858.25	$130,299.00

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the Department of Health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information.

NOTE:

If I obtain health insurance coverage, while under the FBCC, it is my responsibility to notify the REGIONAL FBCC office as soon as possible.

Signature_____

Date _____

If you have any questions, please call the regional coordinator at 407-665-3185 between 8:00 a.m. and 5:00 p.m., Monday through Friday. We will make every effort to return your call in a timely manner.

I further understand that all my screening and diagnostic procedures must be completed within 60 days or payment for these services CANNOT be guaranteed.

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: FLORIDA DEPARTMENT OF HEALTH - SEMINOLE COUNTY

Agency Address: 400 W. AIRPORT BLVD. SANFORD, FL 32773

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

_____ By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ Client/Representative Signature

_____ Self or Representative's Relationship to Client

_____ Date

_____ Witness (optional)

_____ Date

PART VII **WITHDRAWAL OF CONSENT**

I, _____ Client/Representative Signature WITHDRAW THIS CONSENT, effective _____ Date

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: Florida Breast and Cervical Cancer Early Detection Program Phone #: 407-665-3185

Address: 400 W. Airport Blvd., Sanford, FL 32773 Fax # : 407-665-3302

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ Phone #: _____

Fax #: _____

METHOD OF DISCLOSURE:

_____ Pick up at Clinic/Facility

Address: _____

Fax #: _____

_____ Email Address: _____

(Please note that emailing may not be a secured method of communication)

INFORMATION TO BE DISCLOSED: (**Initial** Selection)

_____ General Medical Record(s), including STD and TB _____ Progress Notes _____History and Physical Results

_____ Immunizations _____Family Planning _____Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test (s)) _____

_____ Other: (Specify): _____

I Specifically authorize release of information relating to: (**Initial** Section)

_____ HIV test results for non-treatment purposes _____ Substance Abuse Service Provider Client Records

_____ Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____ WIC

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify) Provider Reimbursement & Care Coordination

EXPIRATION DATE: This authorization will expire (insert date or event) one year from signature date. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be disclosed by the recipient and the information my not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize the treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization anytime. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Client/Legal Representative Signature Date

_____ _____

Printed Name Legal Representative's Relationship to Client

_____ _____

Witness (optional) Date

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information (for example, power of attorney, healthcare surrogate form, order or appointment of a guardianship, order appointing personal representative and letters of administration).

Client Name: _____

ID#: _____

DOB: _____

Original: To File Copy to Client

ATTACH A LEGIBLE COPY OF YOUR IDENTIFICATION

ATTACH A COPY OF YOUR PROVIDER'S REFERRAL OR SCRIPT

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 READ IT CAREFULLY

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic, social and behavioral determinants of health (SBDOH), and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, Social Security number and any other means of identifying you as a specific person. SBDOH may include, but not be limited to, income, food insecurity, socioeconomic status, education level, homeless. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health (Department) can act as each of the above business types. This medical information is used by the Department in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department may use or disclose your health information for case management and services. The Department clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.

Your information may be used by certain Department personnel to improve the Department's health care operations. The Department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the Department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the Florida Legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals*.
- District medical examiner investigations*.
- Research approved by the Department.
- Court orders, warrants, or subpoenas.*
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings*.

*A disclosure of reproductive health records by the Department to law enforcement, a judicial or administrative tribunal, medical examiner, or health oversight entity will require an attestation by

the requesting individual or entity before such records are released by the Department. The attestation requires acknowledgment of one of the following provisions:

- The purpose of the use or disclosure of protected health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes; or alternatively,
- The purpose of the use or disclosure of protected health information is to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was not lawful under the circumstances in which it was provided.

Other uses and disclosures of your protected health information by the Department will require your written authorization. These uses and disclosures may be for marketing or research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in compensation to the Department,

This authorization will have an expiration date that can be revoked by you in writing.

INDIVIDUAL RIGHTS

You have the right to request that the Department restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The Department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where the Department may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department within 30 days of the Department's receipt of your request to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclose Confidential Information form and submit the request to the local county health department or Children's Medical Services office. If there are delays in the Department's ability to provide the information to you within 30 days, you will be told the reason for the delay and the anticipated date your request can be fulfilled.

Your inspection of the information will be supervised at an appointed time and place. You may be denied access to some records as specified by federal or state law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, you will be given the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time, the Department is not required to keep the record and the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the Department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the Department.
- Is not protected health information.
- Is, by law, not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the Department will make the correction and inform you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The Department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled persons.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail, text, or call you with health care appointment reminders.

PARTICIPATION IN THE HEALTH INFORMATION EXCHANGE NETWORK

Access to information about your health history, societal and behavorial factors, and medical care is critical to help ensure that you receive high-quality care and gives your health care provider a more complete picture of your overall health. This can help your provider make informed decisions about your care. The information may also prevent you from having repeat tests, saving you time, money, and worry. Recent advancements in technology now support the safe and secure electronic exchange of important clinical information from one health care provider to another through Health Information Exchange (HIE) networks. The Department and its county health departments participate in an HIE network and also participate in several HIE

networks with trusted outside health care providers to quickly and securely share your health information electronically among a network of health care providers, including physicians, hospitals, laboratories and pharmacies. Your health information is transmitted securely and only authorized health care providers with a valid reason may access your information. By sharing information electronically through a secure system, the risk that your paper of faxed records may be misused or misplaced is reduced.

Participation in HIE is completely your choice.

Choice 1. YES to HIE participation. If you agree to have your medical information shared through HIE and you have a current Initiation of Services form on file, you need not do anything, By signing that form, you have granted the Department permission to share your health information through the HIE.

Choice 2. NO to HIE participation. You can choose to not have your information shared electronically through the HIE network (opt out) at any time, by completing the Health Information Exchange Opt-Out Form available at the county health department. If you decide to opt out of HIE, health care providers will not be able to access your health information through HIE. You should understand that if you opt out, the health care providers treating you are still permitted to contact the Department to ask that your health information be shared with them as stated in this Notice of Privacy Practices. Opting out does not prevent information from being shared between members of your care team. Please note, opting out does not affect health information that was disclosed through HIE prior to the time you opted out.

Choice 3. You may change your mind at any time.
You may consent today to the sharing of your information via HIE and change your mind later by following the instructions on the opt out form described under Choice 2.

Alternatively, you may opt out of HIE today and change your mind later by submitting the Department's Revocation of HIE Opt Out Request Form.

PERSONAL HEALTH RECORDS (PHR) MOBILE APPLICATION SYNCHRONIZATION WITH USER DATA

As part of the services provided by the Department, you can download the companion PHR mobile application to access your personal health records. This application is the mobile version of the Florida Health Connect portal.

The purpose of the PHR mobile application is to provide you with access to your health information through your mobile device. You can synchronize your Florida Health Connect account through the mobile application with your personal health information captured on your mobile device (Google Fit or Apple Health) to provide you with a 360 degree view of your health history and current health status.
Your Google Fit or Apple Health information will not be disclosed to any third parties without your express written permission.

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DEPARTMENT OF HEALTH DUTIES

The Department is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the Department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The Department has

the responsibility to notify you following a breach of your unsecured protected health information.

As part of the Department's legal duties, this Notice of Privacy Practices must be given to you. The Department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department may change the terms of its notice. The change, if made, will be effective for all protected health information maintained by the Department. New or revised Notices of Privacy Practices and all forms referenced in this Notice of Privacy Practices may be accessed on the Department's website at https://www.floridahealth.gov/about/patient-rights-and-safety/hipaa/index.html and will be available by email and at all Department of Health locations. Also available are additional documents that further explain your rights to inspect, copy, or amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning February 25, 2025, and shall remain in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).

HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).

45 CFR Parts 160 and 164 RIN 0945-AA20, April 26, 2024.