Hospice of the Bluegrass

Bereavement Department

Consent for Services

Date:_____

Client Name: _____ Home:_____

Address: _____ Work:_____

City: _____ Zip:_____

Referred By: _____

*I, _____, hereby consent to services provided by the Bluegrass Center for Grief Education and Counseling Staff/Bereavement Department.

*Client Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date:_____

Staff/Witness Signature: _____ Date:_____

***** If the client is under age 18, parent/guardian must also sign consent.

CHILD/ADOLESCENT BEREAVEMENT HISTORY
PARENT/GUARDIAN REPORT

Please assist us in understanding your child's loss experience by providing answers to the following questions.

1. PERSONAL INFORMATION ABOUT YOUR CHILD/ADOLESCENT

Name: _____ Nickname: _____
(Please print)

Date of Birth: ____/_____/_____ Age: _____ School attends: _____

OTHER HOUSEHOLD MEMBERS:

Name	Age	Relationship to child/adolescent

Are there parents/guardians living at different addresses? ❑ Yes ❑ No

If yes, how may we reach them? _____

Please state your reason for wanting your child to attend camp: _____

Has your child had a physical/medical exam since the illness/death? ❑ Yes ❑ No

Has your child received any professional support since the illness/death? ❑ Yes ❑ No

If yes, please check all that apply:

- ❑ Hospice Bereavement Care
- ❑ Minister, Priest, Rabbi, etc.
- ❑ Family Physician
- ❑ School Counselor
- ❑ Other Counselor
- ❑ Other _____

Is your child currently taking any medications? ❑ Yes ❑ No

If yes, please list: _____

Please check if either of the following statements is true:

- ❑ Child/adolescent has not been told the facts about the family member's illness or death.
- ❑ Child/adolescent does not understand the facts about the family member's illness or death.

If either is checked, please explain: _____

How would you describe the child's/adolescent's relationship with this person? _____

2. INFORMATION ABOUT YOUR LOSS **(If this does not apply to you, skip to section 3)**

Name of the person who died:_____

Their relationship to your child: _____ Date of death:_____

Age of deceased: _____ Was this person a Hospice patient? ❑ Yes ❑ No

Place of death: ❑ Home ❑ Hospital ❑ Other

Nature of death: ❑ Illness ❑ Accident ❑ Homicide ❑ Suicide

Is this your child's first experience of death? ❑ Yes ❑ No

Did your child attend the funeral/memorial? ❑ Yes ❑ No

3. PREVIOUS LOSSES

Relationship	Cause of Death	Date of Death

Please note any other recent losses, changes, stressors in your child's life (i.e. divorce, illness, move, finances): _____

_____

4. REACTION TO THE LOSS

Please place a "X" in the column that best answers the question.

General Questions/Behaviors Has your child shown any of the following behaviors**?**	Before illness/death	Since illness/death	Not at all
Expression of disbelief and/or numbness			
Feeling angry a lot			
Feeling nervous or anxious			
Worried about his/her safety or the safety of loved ones			
Always trying to act perfect/in control			
Expression of relief			
Belief that illness/death was his/her fault			
Belief that illness/death is a punishment			
Problems at work or in school			
Withdrawing from family and friends			
Problems sleeping			
Having disturbing dreams			
Problems with appetite			
Change in weight			
Headaches, stomach aches, backaches, etc.			

General Questions/Behaviors Has your child shown any of the following behaviors**?**	Before illness/death	Since illness/death	Not at all
Increase in use of alcohol and/or drugs			
Change in how he/she feels about self			
Lack of energy			
Loss of interest in usual activities			
Exhibiting inappropriate and/or sexually acting out behavior			
Difficulty with concentration and/or memory			
Expressing longing to be with the deceased			
Expressing thoughts of suicide			
Expressing feelings of intense loneliness or isolation			
Having more accidents or injuries than usual			

Which of the following activities have been helpful to your child:

- ❑ Talking with a friend
- ❑ Talking with family
- ❑ Writing or drawing
- ❑ Talking or writing to person who died
- ❑ Physical activity/sports
- ❑ Visiting grave
- ❑ Talking with other supportive person (i.e. minister, teacher)
- ❑ Other _____

5. OTHER IMPORTANT INFORMATION

Has your child ever experienced abuse of any kind? ❑ Yes ❑ No

Has your child or another member of your family experienced emotional or mental health issues for which they received professional support? ❑ Yes ❑ No

If yes, please explain: _____

_____

Are there other things we should know about your child?_____

_____

_____

How do you prefer our staff to contact you?

- ❑ Telephone: _____ ❑ Cell Phone: _____
- ❑ E-mail: _____

This bereavement history is correct to the best of my knowledge.

_____ _____

Signature Date

Please check one: ❑ Parent ❑ Legal guardian

Camp HOPE

HEALTH HISTORY FORM

Child's Name_____
Last First Middle

Home Address _____

_____
City State Zip

Date of Birth_____ Age_____ Male ❑ Female ❑

Mother's/Guardian's Name_____

Day Phone_____ Evening Phone_____

Father's/Guardian's Name_____

Day Phone_____ Evening Phone_____

In case of emergency and parent/guardian cannot be reached, contact:

Name_____

Day Phone_____ Evening Phone_____

Name_____

Day Phone_____ Evening Phone_____

HEALTH HISTORY (check those that apply)

___Asthma
___Convulsions/seizures
___Constipation
___Diabetes
___Emotional Problems
___Fainting
___Heart disease
___Menstrual cramps
___Nose bleeds
___Special dietary needs
___Wears glasses
___Other

___Ear infections
___Epilepsy
___Hearing impairment
___Kidney disease
___Motion sickness
___Sickle cell anemia
___Wears contact lenses
___Allergies to
  ___Food
  ___Animals
  ___Medicines
  ___Other_____

Other (specify)

_____

_____

Please explain any "checked" answers from last question. Indicate any information useful to the adult in charge in relation to any of the health conditions. Also indicate any activities to be encouraged or restricted.

_____

_____

_____

_____

_____

_____

MEDICATIONS*:*
Please list current medications prescribed for your child to take while at Camp HOPE and the purpose of each.

Name of Medication	Purpose
1._____	_____
2._____	_____
3._____	_____
4_____	_____
5._____	_____
6._____	_____
7._____	_____
8._____	_____

List date of child's last Tetanus Injection:_____

I give permission to the camp nurse to administer prescriptions, over the counter medications, first aid and/or access to medical treatment if needed to/for my child.

_____ _____
Signature of Parent/Guardian Date

The hospital closest to camp requires a patient's social security number. If you wish to provide it, this information will only be released in the event of a hospital visit. Social Security # _____

INFORMED CONSENT AND INDEMNIFICATION AGREEMENT

1. We/I, _____, hereby give permission for our/my child, _____ to be transported and to attend Camp HOPE on _____. We/I understand that the camp's goal is to help facilitate the bereavement process of our/my child and provide support for him/her in expressing feelings of grief.

2. In consideration of the above-named child being granted permission by Hospice of the Bluegrass to attend Camp HOPE:

   WE/I, FOR OURSELVES/MYSELF AND ON BEHALF OF OUR/MY CHILD, RELEASE AND DISCHARGE HOSPICE OF THE BLUEGRASS, AND THEIR AGENTS, EMPLOYEES, VOLUNTEERS, OFFICERS, DIRECTORS, SUCCESSORS, AND ASSIGNS (HEREINAFTER COLLECTIVELY "HOSPICE") FROM ALL CLAIMS, DEMANDS, ACTIONS AND JUDGEMENTS WHICH WE/I OR OUR/MY CHILD EVER HAD OR NOW HAS OR MAY HAVE AGAINST HOSPICE FOR ALL PERSONAL INJURIES, EITHER PHYSICAL OR EMOTIONAL, KNOWN OR UNKNOWN, AND INJURY TO PROPERTY, REAL OR PERSONAL, SUSTAINED BY OUR CHILD'S PERSON OR PROPERTY DURING HIS OR HER ATTENDANCE OF CAMP HOPE , WHETHER THE INJURY IS CAUSED BY NEGLIGENCE OR ANY OTHER FAULT.

3. Also, in consideration of the above-named child/children being granted permission by Hospice of the Bluegrass to attend Camp HOPE:

   WE/I AGREE, JOINTLY AND SEVERALLY TO INDEMNIFY AND HOLD HARMLESS HOSPICE FOR ANY AND ALL CLAIMS, DEMAND, ACTIONS, AND JUDGMENTS WHATSOEVER OF EVERY NAME AND NATURE, BOTH IN LAW AND EQUITY, WHICH OUR/MY CHILD EVER HAD OR NOW HAS OR MAY HAVE AGAINST HOSPICE FOR ALL PERSONAL INJURIES, EITHER PHYSICAL OR EMOTIONAL, KNOWN OR UNKNOWN, AND INJURY TO PROPERTY, REAL OR PERSONAL, SUSTAINED BY OUR/MY CHILD'S PERSON OR BUT NOT LIMITED TO, INJURY CAUSED BY OR ARISING FROM HOSPICE'S OWN NEGLIGENCE.

We, the undersigned, have read this release and understand all of its terms.

_____ _____

Date Parent/Guardian Signature

_____ _____

Date Parent/Guardian Signature

HOSPICE OF THE BLUEGRASS
AUTHORIZATION FORM

Client Name: _____ Birth Date: _____ / _____ /_____
MM / DD / YR

Address: _____

_____

Home Telephone Number: _____ E-mail:_____

Work Telephone Number: _____

Client Identification Number and/or Social Security Number: _____

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below, whom I am authorizing to use and/or disclose my health information, may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

1. I Authorize the Following Health Information to be Used and/or Disclosed.

( ) Photograph

( ) Interview (audiotaped and/or videotaped)

( ) Interview (for written publication)

( ) Name

( ) Name in reference to being in the Hospice program

( ) Written work(s)

( ) Artwork

( ) Other: _____

2. I Authorize the Following Persons/Organizations to Use and/or Disclose My Health Information:

Hospice of the Bluegrass _____

_____

3. I Authorize the Following Persons/Organizations to Receive and/or Use My Health Information:

Hospice of the Bluegrass _____

_____

4. I Authorize My Health Information to Be Used and/or Disclosed for:

Internal and/or External Educational and Promotional Purposes. _____

HOSPICE OF THE BLUEGRASS
AUTHORIZATION FORM

5. My Right to Revoke This Authorization. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form, I may contact the Director of Information Management Systems/Privacy Officer at Hospice of the Bluegrass, (859)276-5344. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

6. Re-disclosure of My Health Information. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

7. Disclosure of Direct or Indirect Remuneration Received by Any Person and/or Organization Authorized to Use and/or Disclose My Health Information. I understand that N/A _____ will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information.

8. Expiration of Authorization. This authorization will be effective until the following date or event in which Hospice of the Bluegrass no longer needs photos or information:

_____

_____

_____ _____/_____/_____

Client Signature Date

If Client is unable to sign, complete the following:

Client is unable to sign because: _____

Name of Personal Representative and Relationship to Client: _____

_____

Authority of Personal Representative (*e.g.,* health care power of attorney, guardian, other statutory authorization): _

Address: _____

Home Telephone Number: _____ E-mail:_____

Work Telephone Number: _____

_____ _____/_____/_____

Signature of Personal Representative Date

HOSPICE OF THE BLUEGRASS
RECEIPT OF NOTICE OF PRIVACY PRACTICES

Client Name: _____
Medical Record #: _____
Date of Admission: _____

My signature on this form acknowledges that I have received a copy of Hospice of the Bluegrass' Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Hospice of the Bluegrass and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

_____ _____
Client's Signature Date

_____ _____
Signature of Client's Guardian/ Representative if client is unable to sign Date

TO BE COMPLETED BY ADMITTING COUNSELOR IF FORM IS NOT SIGNED

1. Was the client provided with a copy of Hospice of the Bluegrass' Notice of Privacy Practices? ❑ Yes ❑ No

2. Briefly describe efforts made to obtain the client's acknowledgment of receipt of the Notice and explain why the client was not able or willing to sign this form.

_____

_____

_____

_____ _____
Signature of Admitting Counselor Date

Privacy Practices are on the following 5 pages. The following pages do not need to be turned in with the camp application.

NOTICE OF HOSPICE OF THE BLUEGRASS 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.

USE AND DISCLOSURE OF HEALTH INFORMATION

_____ ***Hospice of the Bluegrass*** may use your health information for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. Your health information may be used or disclosed only after Hospice of the Bluegrass has obtained your written consent. Hospice of the Bluegrass has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AFTER YOU HAVE PROVIDED YOUR WRITTEN CONSENT:

To Provide Treatment. Hospice of the Bluegrass may use your health information to coordinate care within Hospice of the Bluegrass and with others involved in your care, such as your attending physician, members of Hospice of the Bluegrass interdisciplinary team and other health care professionals who have agreed to assist Hospice of the Bluegrass in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. Hospice of the Bluegrass also may disclose your health care information to individuals outside of Hospice of the Bluegrass involved in your care including family members, clergy whom you have designated, pharmacists, suppliers of medical equipment or other health care professionals that Hospice of the Bluegrass uses in order to coordinate your care.

To Obtain Payment. Hospice of the Bluegrass may include your health information in invoices to collect payment from third parties for the care you may receive from Hospice of the Bluegrass. For example, Hospice of the Bluegrass may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or Hospice of the Bluegrass. Hospice of the Bluegrass also may need to obtain prior approval from your insurer and may need to explain to the insurer your need for hospice care and the services that will be provided to you.

To Conduct Health Care Operations. Hospice of the Bluegrass may use and disclose health care information for its own operations in order to facilitate the function of Hospice of the Bluegrass and as necessary to provide quality care to all of the Hospice of the Bluegrass patients. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Protocol development, case management and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees or practitioners in health care learn under supervision.
- Training of non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.

- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.

- Business planning and development including cost management and planning related analyses and formulary development.

- Business management and general administrative activities of Hospice of the Bluegrass.

- Fundraising for the benefit of Hospice of the Bluegrass and certain marketing activities.

For example Hospice of the Bluegrass may use your health information to evaluate its staff performance, combine your health information with other Hospice of the Bluegrass patients in evaluating how to more effectively serve all Hospice of the Bluegrass patients, disclose your health information to Hospice of the Bluegrass staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you or your family as part of general fundraising and community information mailings (unless you tell us you do not want to be contacted).

Hospice of the Bluegrass may disclose certain information about you including your name; your general health status, your religious affiliation and where you are in the Hospice Care Center in a Hospice of the Bluegrass directory while you are in the Hospice Care Center. Hospice of the Bluegrass may disclose this information to people who ask for you by name. Please inform us if you do not want your information to be included in the directory.

For Fundraising Activities. Hospice of the Bluegrass may use information about you including your name, address, phone number and the dates you received care at Hospice of the Bluegrass in order to contact you or your family to raise money for Hospice of the Bluegrass. Hospice of the Bluegrass may also release this information to a related Hospice foundation. If you do not want Hospice of the Bluegrass to contact you or your family, notify ***Vice President Development/859-276-5344*** and indicate that you do not wish to be contacted.

Federal privacy rules allow Hospice of the Bluegrass to use or disclose your health information without your consent or authorization for a number of reasons.

When Legally Required. Hospice of the Bluegrass will disclose your health information when it is required to do so by any Federal, State or local law.

When There Are Risks to Public Health. Hospice of the Bluegrass may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as death and the conduct of public health surveillance, investigations and interventions.

- To report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with

  requirements of the Food and Drug Administration.

- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.

- To an employer about an individual who is a member of the workforce as legally required.

NOTICE OF HOSPICE OF THE BLUEGRASS PRIVACY PRACTICES

To Report Abuse, Neglect Or Domestic Violence. Hospice of the Bluegrass is allowed to notify government authorities if Hospice of the Bluegrass believes a patient is the victim of abuse, neglect or domestic violence. Hospice of the Bluegrass will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. Hospice of the Bluegrass may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Hospice of the Bluegrass, however, may not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

In Connection With Judicial And Administrative Proceedings. Hospice of the Bluegrass may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Hospice of the Bluegrass makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

To Coroners And Medical Examiners. Hospice of the Bluegrass may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.

To Funeral Directors. Hospice of the Bluegrass may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, Hospice of the Bluegrass may disclose your health information prior to and in reasonable anticipation, of your death.

For Organ, Eye Or Tissue Donation. Hospice of the Bluegrass may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

For Research Purposes. Hospice of the Bluegrass may, under very select circumstances, use your health information for research. Before Hospice of the Bluegrass discloses any of your health information for such research purposes, the project will be subject to an extensive approval process. Hospice of the Bluegrass will ask your permission if any researcher will be granted access to your individually identifiable health information.

In the Event of A Serious Threat To Health Or Safety. Hospice of the Bluegrass may, consistent with applicable law and ethical standards of conduct, disclose your health information if Hospice of the Bluegrass, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, the Federal regulations authorize Hospice of the Bluegrass to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For Worker's Compensation. Hospice of the Bluegrass may release your health information for worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than is stated above, Hospice of the Bluegrass will not disclose your health information other than with your written authorization. If you or your representative authorizes Hospice of the Bluegrass to use or disclose your health information, you may revoke that authorization in writing at any time.

NOTICE OF HOSPICE OF THE BLUEGRASS PRIVACY PRACTICES

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Hospice of the Bluegrass maintains:

- **Right to request restrictions**. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Hospice of the Bluegrass's disclosure of your health information to someone who is involved in your care or the payment of your care. However, Hospice of the Bluegrass is not required to agree to your request. If you wish to make a request for restrictions, please contact ***Director Information Systems Management/Privacy Officer/859-276-5344.***

- **Right to receive confidential communications**. You have the right to request that Hospice of the Bluegrass communicate with you in a certain way. For example, you may ask that Hospice of the Bluegrass only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact ***Director Information Systems Management/Privacy Officer 859-276-5344.*** Hospices of the Bluegrass will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

- **Right to inspect and copy your health information**. You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to ***Director Information Systems Management/Privacy Officer.*** If you request a copy of your health information, Hospice of the Bluegrass may charge a reasonable fee for copying and assembling costs associated with your request.

- **Right to amend health care information**. If you or your representative believes that your health information records are incorrect or incomplete, you may request that Hospice of the Bluegrass amend the records. That request may be made as long as the information is maintained by Hospice of the Bluegrass. A request for an amendment of records must be made in writing to ***Director Information Systems Management/Privacy Officer***]. Hospice of the Bluegrass may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by Hospice of the Bluegrass, if the records you are requesting are not part of the Hospice of the Bluegrass records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of Hospice of the Bluegrass, the records containing your health information are accurate and complete.

- **Right to an accounting**. You or your representative have the right to request an accounting of disclosures of your health information made by Hospice of the Bluegrass for any reason other than for treatment, payment or health operations. The request for an accounting must be made in writing to ***Director Information Management Systems/Privacy Officer.*** The request should specify the time period for the accounting starting on April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. Hospice of the Bluegrass would provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

- **Right to a paper copy of this notice**. You or your representative has a right to a separate paper copy of this Notice at any time even if you or your representative has received this Notice previously. To obtain a separate paper copy, please contact***, Director Information Systems Management/Privacy Officer. [A Hospice of the Bluegrass patient or a representative may also obtain a copy of the current version of Hospice of the Bluegrass's Notice of privacy practices at its website, www.hospicebg.com.***

NOTICE OF HOSPICE OF THE BLUEGRASS PRIVACY PRACTICES

DUTIES OF HOSPICE OF THE BLUEGRASS

Hospice of the Bluegrass is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. Hospice of the Bluegrass is required to abide by terms of this Notice as may be amended from time to time. Hospice of the Bluegrass reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If Hospice of the Bluegrass changes its Notice, Hospice of the Bluegrass will provide a copy of the revised Notice to you or your appointed representative. You or your personal representative has the right to express complaints to Hospice of the Bluegrass and to the Secretary of Health and Human Services if you or your representative believe that your privacy rights have been violated. Any complaints to Hospice of the Bluegrass should be made in writing to ***Director Information Management Systems/Privacy Officer***. Hospice of the Bluegrass encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

Hospice of the Bluegrass's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is ***the Director Information Management Systems/ Privacy Officer; 2312 Alexandria Drive; Lexington, KY 40504.***

EFFECTIVE DATE

This Notice is effective April 14, 2003.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT Cindy Cummings, RHIT.