LSU Health NEW ORLEANS
School of Allied Health Professions
HUMAN DEVELOPMENT CENTER
BUILDING CAPACITY•INSPIRING CHANGE

Louisiana Deafblind Project Referral Packet

LADBP Enrollment Welcome Letter

Dear Parents/Guardian:

Thank you for enrolling your child with the **Louisiana Deafblind Project for Children and Youth.** Students qualify for inclusion in the **Project**'s work when they present with concomitant, permanent hearing and vision impairment resulting in communication, developmental and/or educational needs that cannot be accommodated in special education programs solely for children with deafness or children with blindness.

Verification regarding your child's hearing and vision impairment is required. Also, verification of your child's need for special education services is required. These verifications can be accomplished by providing the **Project** copies of hearing evaluations, vision evaluations, educational evaluations, Individual Education Plan (IEP) or Individual Family Service Plan (IFSP). All information regarding your child is held in confidence.

Personal education and healthcare information is protected by Federal laws including the *Family Educational Rights & Privacy Act (FERPA) & Health Insurance Privacy & Accountability Act (HIPAA).* These laws make sure your child's educational & health information is kept private and requires that we give you notice of our legal duties and privacy practices. Included in this packet of information is a *Notice of Privacy Practices Protected Health Information* which details our obligations under *HIPPA.* Please review this document. Once reviewed, please complete the *Acknowledgement of Receipt of Notice of Privacy Practices* form and return it to the Louisiana Deafblind Project along with the other application materials. The following check-list may assist you in organizing the needed information for your child.

Documents in This Packet

- [ ] LADBP Registry Referral Application Form
- [ ] Consent to Register with the Louisiana Deafblind Project

Documents Available via the LADBP Technical Assistance Page, http://www.hdc.lsuhsc.edu/ladbp/ladbptechassisstance.aspx

- [ ] Notice of Privacy Practices Regarding Your Protected Health Information (HIPAA) (text does not need to be included in final application)
- [ ] Notice of Privacy Practices Confirmation (HIPAA)
- [ ] Authorization for Release of Protected Health Information (HIPAA)

Additional Required Official Documentation

- [ ] Hearing Loss Documentation
- [ ] Vision Loss Documentation
- [ ] Educational Documentation

Thank you again for enrolling your child with the **Louisiana Deafblind Project for Children and Youth.** We look forward to working with your child and your family.

Sincerely,

Michael C. Norman, Coordinator

LADBP Registry Referral Application

*Today's Date

mm/dd/yyyy

Information about Child/Youth with Deafblindness

*Last Name

*First Name

Middle Name

*School

*Mailing Address

*City

*Parish

*Zip

*Phone Type (check one):

Voice TTY VP

*Phone Number

(###) ###-####

*Date of Birth

mm/dd/yyyy

* Male Female

*Cause of Hearing Impairment

*Cause of Vision Impairment

Syndrome/Other Conditions

Information about the Person Completing This Form

*Relationship to Individual Listed Above

*Last Name

*First Name

*Address

*City | *Parish/County | *State | *Zip

*Phone Type (check one):

Voice TTY VP

*Phone Number

(###) ###-####

Consent to Register with the Louisiana Deafblind Project

I do consent to register my child

with the Louisiana Deafblind Project for Children and Youth. I understand that the work of the Louisiana Deafblind Project may include but is not limited to the following:

- Obtaining information regarding your child from other agencies
- Sharing information regarding your child to other agencies
- Observing your child in home, school, and social environments
- Listing your child as a member of the Louisiana Deafblind Registry, a registry of students with deafblindness in Louisiana
- Reviewing medical records to confirm hearing and vision impairments
- Updating demographic information a minimum of every three (3) years
- Reporting aggregated/deidentified data to the U.S. Department of Education, Office of Special Education Programs

By signing this form, you indicate your desire to register your child with the Louisiana Deafblind Project. You have the right to revoke this consent, in writing, except where disclosures have been made in reliance on your prior consent. I have read all of the above, and I certify that I understand its contents.

Parent Signature

Date

mm/dd/yyyy

Other Authorized Signature

Date

mm/dd/yyyy

Emergency Contact

Telephone Number

(###) ###-####

Notice of Privacy Practices Regarding Your Protected Health Information
This Notice Describes How Medical/Dental Information About You May Be Used and Disclosed and How You Can Get Access to this Information. Please Review it CAREFULLY.

The law requires us to make sure your medical information is kept private. It also requires us to give you this notice of our legal duties and privacy practices to tell you what we can do with the medical information about you. To better understand this law, you may want to read it. It is in Title 45 of the Code of Federal Regulations, Part 164. In the unlikely event that the information we have about you should be obtained by someone who is not supposed to have it, the law requires us to notify you. We are required to follow the practices outlined in this notice. We have the right to change this notice and our privacy practices in the future. Any changes made will apply to all of the medical information we have about you at this time. If we make a change, we will put up a notice in our building. We will also give you a copy of the new notice if you ask for it. You can also read about these changes on the computer at this website: www.lsuhsc.edu

HOW YOUR MEDICAL/DENTAL INFORMATION MAY BE USED: In general, we may use your medical information in a number of ways:

To provide patient care to you. Your medical information may be used by the doctors, nurses and other professionals who are treating you. For example, your medical information is used to help them find out your problems or condition, and to decide the best way to treat you.

Appointment reminders. We may use your medical information to contact you to remind you of appointments, and to give you information about other treatment options or other health-related benefits and services that may be of interest to you.

To obtain payment. Your medical information may also be used by our business office to prepare your bill and process payments from you as well as from any insurance company, government program or other person who is responsible for payment.

For our health care operations. Your medical information may be used to review the quality and appropriateness of the care you receive. We may also use your medical information to put together information to see how we are doing and to make improvements in the services and care we give you. In some cases we may have students, trainees, or other health care personnel, as well as some non-health care personnel, who come to our facility to learn under the guidance of faculty to practice or improve their skills.

To create de-identified databases. We may use your medical information for the purpose of removing your personal information that tells anyone who you are, and putting it into a computer program. Your information may be completely de-identified where all identifying information is removed or partially de-identified but includes information such as gender and zip codes. This information is often used for research purposes. If your information is partially de- identified, it is called a "limited data set."

Fundraising. We may use your medical information to raise funds for our organization directly or to raise funds for our organization through an institutionally – related foundation or business associate. You may receive

communications about these fundraising activities. You have the right to request that you not be contacted by us for purposes of fundraising and we must agree to your request.

HOW YOUR MEDICAL/DENTAL INFORMATION MAY BE DISCLOSED: In addition to using your medical information, we may disclose all or part of it to certain other people. This includes giving your information to:

You. In order to get your medical information, you will need to fill out an authorization form. You may also have to pay for the cost of some or all of the copies.

People You Authorize. If you tell us that you want us to give your medical information to someone, we will do so. You will need to fill out an authorization form. We must obtain your written authorization before disclosing information you may have shared with one of our psychiatrists, psychologists or counselors in a private session, or to use your information to market our services, or to sell your information. We must obtain your authorization to use or disclose your information in any way that is not otherwise described in this notice. You may stop this authorization at any time. We are not allowed to force you to give us permission to give your medical information to anyone. We cannot refuse to treat you because you stop this authorization.

Payers. We have the right to give your medical information to insurance companies, government programs such as **Medicare and Medicaid**, and their contractors who process your claims, as well as to others who are responsible for paying all or part of the cost of treatment provided to you. For example, we may tell your health insurance company what is wrong with you and what treatment is recommended or has been given to you.

Business Associates. Business Associates are companies or people we contract with to do certain work for us. Examples include billing services, information auditors, attorneys and specialized people providing management, analysis, utilization review or other similar services to us. Another example is giving health information to a Business Associate so that they can create a de-identified database. All Business Associates are required to agree to take reasonable steps to protect the privacy of your medical information.

Limited Data Set Recipients. If we use your information to make a "limited data set," we may give the "limited data set" that includes your information to others for the purposes of research, public health action or health care operations. The persons who receive the "limited data set" are also required to agree to take reasonable steps to protect the privacy of your medical information.

The Secretary of the U.S. Department of Health and Human Services. The Secretary has the right to see your records in order to make sure we follow the law.

Public Health Authorities. We may disclose your medical information to a public health authority responsible for preventing or controlling disease, maintaining vital statistics or other public health functions. We may also give your medical information to the Food and Drug Administration in connection with FDA-regulated products.

Law Enforcement Officers. We may reveal your medical information to the police. We may also give your medical information to persons whose job is to receive reports of abuse, neglect or domestic violence. And, if we believe that releasing this information is needed to prevent a serious threat to the health or safety of a person or the public, we are permitted to reveal your medical information.

Health Oversight Agencies. We may give your medical information to agencies responsible for health oversight activities, such as investigations and audits, of the health care system or benefits programs, as allowed by law.

Courts and Administrative Agencies. We may reveal your medical information as required by a judge for a legal issue.

Coroners and Administrative Agencies. If you die, we may reveal medical information about your death to coroners, medical examiners and funeral directors, as allowed by law.

Tissue Donation and Organ Transplant Services. We may reveal your medical information to agencies that are responsible for obtaining tissue donations and obtaining and transplanting organs.

Research. We may reveal your medical information in connection with certain research activities. With your authorization, we may disclose pertinent information such as your name, social security number, study name, and dates of participation to our Accounts Payable department to issue human subjects research incentive payments.

Specialized Governmental Functions. We may disclose your medical information for certain specialized governmental functions, as allowed by law. Such functions include:
• Military and veteran activities
• National security and intelligence activities
• Proactive services to the President and others
• Medical suitability determinations; and
• Correctional institutions and other law enforcement custodial situations.

Required by Law. We may also reveal your medical information in any other circumstances where the law requires us to do so.

OBJECTIONS TO USES AND DISCLOSURES:
In certain situations, you have the right to object before your medical information can be used or revealed. This does not apply if you are being treated for certain mental or behavioral problems. If you do not object after you are given the chance to do so, your medical information may be used:

Patient Directory. In most cases, this means your name; room number and general information about your condition may be given to people who ask for you by name. Also, information about your religion may be given to members of the clergy, even if they do not ask for you by name.

Family and Friends. We may disclose to your family members, other relatives and close personal friends, any medical information that they need to know if they are involved in caring for you. For example, we can tell someone who is assisting with your care that you need to take your medication or get a prescription refilled or give them information about how to care for you. We can also use your medical information to find a family member, a personal representative or another person responsible for your care and to notify them where you are, about your condition or of your death. If it is an emergency or you are not able to communicate, we may still give certain information to persons who can help with your care.

Disaster Relief. We may reveal your medical information to a public or private disaster relief organization assisting with an emergency.

YOUR RIGHTS REGARDING YOUR MEDICAL/DENTAL INFORMATION: You may also have the following rights regarding your medical information:

You have the right to ask us to treat your medical information in a special way, different from what we normally do. Unless it is one of the uses or disclosures to which the law gives you the right to object, we do not have to agree with you. If we do agree to your wishes, we have to follow your wishes until we tell you that we will no longer do so. However, you have the right to request restrictions on disclosures of information about a health care item or service for which you have paid in full out of pocket. We must agree to your request as long as the requested restriction applies to seeking payment or our health care operations and not required by law.

You have the right to tell us how you would like us to send your information to you. For example, you might want us to call you only at work or only at home. Or you may not want us to call you at all. If your request is reasonable, we must follow your request.

You have the right to look at your medical information and, if you want, to get a copy of it. We can charge you for a copy, but only a reasonable amount. Your right to look at and copy your medical records is based upon certain rules. For example, we can ask you to make your request in writing, or, if you come in person, that you do so at certain times of the day.

You have the right to ask us to change your medical information. For example, if you think we made a mistake in writing down what you said about when you began to feel bad, you can tell us. If we do not agree to change your record, we will tell you why, in writing, and give you information about your rights.

You have the right to be told to whom we have given your medical information in the six years before you ask. This does not apply to all disclosures. For example, if we gave someone your medical information so that they could treat you or pay for your care, we do not have to keep a record of that.

You have the right to get a copy of this notice at no charge.

You have the right to complain to us or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights.

If you have a complaint or concern, please call our
24 hour Hotline: 855-561-4099
Your call will be handled by our Privacy Officer.
You may remain anonymous and all calls are kept confidential.
For further information about your rights or about the uses and disclosures of your medical information, please call
The Office of Compliance Programs at: (504) 568-5135 to speak with either our Compliance or Privacy Officer. Or write to:
LSUHSC New Orleans
Office of Compliance Programs
433 Bolivar Street, Room 807
New Orleans, LA 70112
Or email: nocompliance@lsuhsc.edu
This notice is effective as of 4/13/2003
Date Last Revised 2/3/2020

ATTACHMENT B

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of the
(Patient's name – please print)

Notice of Privacy Practices of LSUHSC-NO on this date.

_____ Date: _____
Patient's Signature

****

Health Care Provider's Documentation of Good Faith
Effort to Obtain Acknowledgement of Receipt

If the Acknowledgement **could not be obtained** prior to the date of first service to the patient, or, in an emergency situation, as soon as reasonably practicable after the emergency has resolved, describe below the efforts made to obtain the written Acknowledgement and the reasons why the written Acknowledgement could not be obtained. If the patient refused to provide the written Acknowledgement, please so state.

Efforts to obtain written Acknowledgement:
_____
_____
_____
_____

Reasons written Acknowledgement could not be obtained:
_____
_____
_____
_____

_____ _____
(Signature of health care provider) Date

_____
(Printed name of health care provider)

Authorization for Release of Protected Health Information

ATTACHMENT B

Make two copies. Provide one to patient. Maintain original in LSUHSC-NO Files.

Patient Name: _____ Date of Birth: ____/____/____
Address Street_____
City/State/Zip _____
Social Security #:_____ Telephone: _____

Authority to Release Protected Health Information
I hereby authorize _____ to release the information identified in this authorization form from the medical records of _____ and provide such information to _____.

Information to be Released – Covering the Periods of Health Care: From (date) ____/____/____to (date) ____/____/____
Please check type of information to be released:

__Complete health record	__ Diagnosis & treatment codes	__ Discharge summary	__Psychotherapy Notes
__ History and physical exam	__ Consultation reports	__ Progress notes	(*If above is checked, any other PHI*
__ Laboratory test results	__ X-ray reports	__ X-ray films / images	*must be listed on a separate*
__ Photographs, videotapes	__ Complete billing record	__ Itemized bill	*authorization form*)

__ Other, (specify) _____

Purpose of the Requested Disclosure of Protected Health Information
I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be "at the request of the individual"):_____
_____
If this authorization is for the purposes of marketing or the sale of PHI, will LSUHSC-NO receive any payment as a result of this authorization? Check One: ___Yes ___No ____Initials

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check One: ___ Yes ___ No
I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. Check One: ___Yes ___ No

Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to _____at _____. Unless revoked, this authorization will expire on the following date, or after the following time period or event _____.

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge LSUHSC-NO and its officers, directors, employees and students of any liability and the undersigned will hold them harmless for complying with this Authorization.

Signature: _____ Date: ____/____/____
Description of relationship if not patient:_____