

## NOTICE OF PRIVACY PRACTICES

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

**THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

*If you have any questions about this notice, please contact the ODI Clinic Director at the address or telephone number listed above.*

### WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff, and other office personnel.

### YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office; may be in the form of written or electronic records or spoken words; and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, services and supports, procedures, prescriptions, related billing activity, and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

**For Services & Supports.** We may use health information about you to provide you with clinical services or supports. We may disclose health information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health.

For example, a clinician may be treating you for a behavioral condition and may need to know if you have other health problems that could complicate your treatment. This clinician may use your clinical history to decide what treatment is best for you. The clinician may also tell another doctor about your condition so that the doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning teachers, scheduling lab work, and talking with caseworkers. Family members and other health care providers may be part of your clinical care outside this office and may require information about you that we have.

**For Payment.** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed and payment may be collected from you, an insurance company, or a third party.

For example, we may need to give information about a service you received here to your health plan so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for treatment.

**For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other clients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use

health information about all or many of our clients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosure of your health information to plans and other providers may be for the purpose of helping these plans and providers improve care, reduce costs, coordinate and manage health care and services, train staff, and comply with the law.

**Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment that may be of interest to you.

**Treatment Alternative.** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Products and Services.** We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

## SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

**To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required By Law.** We will disclose health information about you when required to do so by federal, state, or local law.

**Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will be involved in your care at the office or will have access to your name, address, or other information that reveals who you are.

**Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**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 Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury, or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products.

**Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor health care systems, government programs, and compliance with civil rights laws.

**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. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

**Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

## OTHER USES AND DISCLOSURE OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give 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 information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosure already made with your permission.

In some instances, we may need specific, written authorization for you in order to disclose certain types of specifically protected information such as HIV, substance abuse, mental health, and genetic testing information such as treatment, payment and healthcare operations.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as clinical and billing records, that we keep and use to make decisions about your care. You must submit a REQUEST BY CLIENT TO ACCESS THEIR PHI form to the Clinic Director in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your clinical record.

If you request to view a copy of your health information, we will not charge you for inspecting your clinical information. If you wish to inspect your clinical information, please submit a REQUEST BY CLIENT TO ACCESS THEIR PHI form to the Clinic Director. You have the right to request a copy of your health information in electronic form if we store your clinical information electronically.

We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

**Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a CLINICAL RECORD AMENDMENT/CORRECTION FORM to the Clinic Director.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

We did not create, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the health information that we keep;

You would not be permitted to inspect and copy;

Is accurate and complete.

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your clinical record. Your rebuttal needs to be 1 page in length or less and we have the right to file a rebuttal responding to yours in your clinical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the clinical record is disclosed.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of clinical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions, and law enforcement. The list may also exclude any disclosures we have made based on your written authorization.

To obtain this list, you must submit a REQUEST FOR LISTING OF DISCLOSURE form to Clinic Director. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose a particular piece of information presented during the course of treatment.

***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

***We are required to agree to your request*** if you pay for treatment, services, supplies and prescriptions “out of pocket” and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTED USE-DISCLOSURE OF RECORDS form to *the Clinic Director*.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTED USE-DISCLOSURE OF RECORDS form AND/OR REQUEST FOR ALTERNATIVE MEANS OF CONFIDENTIAL INFORMATION form to the Clinic Director. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy of this Notice in the reception area. To obtain such a copy, contact your clinician.

#### CHANGES TO THIS NOTICE

We reserve the right to change this notice and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

#### BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

#### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region X  
Linda Yuu Connor, Regional Manager  
U.S. Department of Health and Human Services  
701 Fifth Avenue, Suite 1600, MS - 11  
Seattle, WA 98104  
Voice Phone (800) 368-1019  
FAX (206) 615-2297  
TDD (800) 537-7697

To file a complaint with our office, contact the ODI Clinic Director at (541) 485-2711. You will not be penalized for filing a complaint.