NOTICE OF PRIVACY PRACTICES &
CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE
PATIENT RECORD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Health information which we receive and/or create about you, personally, in this program, relating to your past, present, or future health, treatment, or payment for health care services, is "protected health information" under the Federal law known as the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by another Federal law as well, commonly referred to as the Alcohol and Other Drug (AOD) Confidentiality Law, 42 C.F.R. Part 2. Generally, the program may not say to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser, or use or disclose any other protected health information except in limited circumstances as permitted by Federal law. Your health information is further protected by any pertinent state law that is more protective or stringent then either of these two Federal laws.

This Notice describes how we protect personal health information (otherwise referred to as "protected health information") we have about you, and how we may use and disclose this information. This Notice also describes your rights with respect to protected health information and how you can exercise those rights.

Uses and disclosures that may be made of your health information:

• **Internal Communications:** Your protected health information will be used within our program that is between and among program staff who have a need for the information, and between our program and in connection with our duty to diagnose, treat, or refer you for substance abuse treatment. This means that your protected health information may be shared between or among personnel for treatment, payment or health care operation purposes. For example: Two or more providers within the program may consult with each other regarding your best course of treatment. may share your protected health information in a billing effort to receive payment for health care services rendered to you. And/or, your protected health information may be discussed within the program about your treatment in connection with others in the program, in an effort to improve the overall quality of care provided by our program.

• **Qualified Service Organizations and/or Business Associates:** Some or all of your protected health information may be subject to disclosure through contracts for services with qualified service organizations and/or business associates, outside of this program, that assist our program in providing health care. Examples of qualified service organizations and/or business associates include billing companies, data processing companies, or companies that provide administrative or specialty services. To protect your health information, we require these qualified service organizations and/or business associates to follow the same standards held by this program through terms detailed in a written agreement.

• **Medical Emergencies:** Your health information may be disclosed to medical personnel in a medical emergency, when there is immediate threat to the health of an individual, and when immediate medical intervention is required. This includes declared medical emergencies resulting from natural disasters.

• **To Researchers:** Under certain circumstances, this office may use and disclose your protected health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one test or treatment to those who received another, for the same condition. All research projects, however, must be approved by an Institutional Review Board, or other privacy review board as permitted within the regulations, that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

• **To Auditors and Evaluators:** This program may disclose protected health information to regulatory agencies, funders, third-party payers, and peer review organizations that monitor alcohol and drug programs to ensure that the program is complying with regulatory mandates and is properly accounting for and disbursing funds received.

• **Authorizing Court Order:** This program may disclose your protected health information pursuant to an authorizing court order. This is a unique kind of court order in which certain application procedures have been taken to protect your identity, and in which the court makes certain specific determinations as outlined in the Federal regulations and limits the scope of the disclosure.

• **Crime on Program Premises or Against Program Personnel:** This program may disclose a limited amount of protected health information to law enforcement when a patient commits or threatens to commit a crime on the program premises or against program personnel.

• **Reporting Suspected Child Abuse and Neglect:** This program may report suspected child abuse or neglect as mandated by state law.

• **As Required by Law:** This program will disclose protected health information as required by state law in a manner otherwise permitted by federal privacy and confidentiality regulations.

• **Appointment Reminders:** This program reserves the right to contact you, in a manner permitted by law, with appointment reminders or information about treatment alternatives and other health related benefits that may be appropriate to you.

• **Other Uses and Disclosure of Protected Health Information:** Other uses and disclosures of protected health information not covered by this notice, will be made only with your written authorization or that of your legal representative. If you or your legal representative authorize us to use or disclose protected health information about you, you or your legal representative may revoke that authorization, at any time, except to the extent that we have already taken action relying on the authorization.

Your rights regarding protected health information we maintain about you:

• **Right to Inspect and Copy:** In most cases, you have the right to inspect and obtain a copy of the protected health information that we maintain about you. To inspect and copy your protected health information, you must submit your request in writing to this office. In order to receive a copy of your protected health information, you may be charged a fee for the photocopying, mailing, or other costs associated with your request. In some very limited circumstances we may, as authorized by law, deny your request to inspect and obtain a copy of your protected health information. You will be notified of a denial to any part or parts of your request. Some denials, by law, are reviewable, and you will be notified regarding the procedures for invoking a right to have a denial reviewed. Other denials, however, as set forth in

the law, are not reviewable. Each request will be reviewed individually, and a response will be provided to you in accordance with the law.

• **Right to Amend Your Protected Health Information:** If you believe that your protected health information is incorrect or that an important part of it is missing, you have the right to ask us to amend your protected health information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to this office. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend protected health information that we believe:

- Is accurate and complete;
- Was not created by us, unless the person or entity that created the protected health information is no longer available to make the amendment;
- Is not part of the protected health information kept by or for us; or
- Is not part of the protected health information which you would be permitted to inspect and copy.

If your right to amend is denied, we will notify you of the denial and provide you with instructions on how you may exercise your right to submit a written statement disagreeing with the denial and/or how you may request that your request to amend and a copy of the denial be kept together with the protected health information at issue, and disclosed together with any further disclosures of the protected health information at issue.

• **Right to an Accounting of Disclosures:** You have the right to request an accounting or list of the disclosures that we have made of protected health information about you. This list will not include certain disclosures as set forth in the HIPAA regulations, including those made for treatment, payment, or health care operations within our program and/or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to this office. Your request must state the time period from which you want to receive a list of disclosures. The time period 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 or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. 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 protected health information we are permitted to use or disclose about you for treatment, payment or health care operations within our program. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request, except in emergency situations where your protected health information is needed to provide you with emergency treatment. We will not agree to restrictions on uses or disclosures that are legally required, or those which are legally permitted and which we reasonably believe to be in the best interest of your health.

• **Right to Request Confidential Communications:** You have the right to request that we communicate with you about protected health information in a certain manner 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 must make your request in writing to this office, and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

• **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, please contact Adams County Integrated Healthcare Services, 425 E. Main, Suite 600, Othello, WA 99344 509-488-5611. You will not be penalized or otherwise retaliated against for filing a complaint**.** If you have questions as to how to file a complaint please contact us at Adams County Integrated Health, 425 E. Main, Suite 600, Othello, WA 99344.

Our responsibilities:

This office is required to:

- Maintain the privacy of your protected health information;
- Provide you with this notice of our legal duties and privacy practices with respect to your protected health information; and,
- Abide by the terms of this notice while it is in effect.

This office reserves the right to change the terms of this Notice at any time and to make a new Notice with provisions effective for all protected health information that we maintain. In the event that changes are made, this office will notify you of a revised Notice by mail [or state other means of intended notification] at the current address provided on your medical file

To receive additional information:

For further explanation of this Notice you may contact didgʷálic Wellness Center at (360) 588-2800.

Availability of Notice of Privacy Practices:

This notice will be posted where registration occurs [or whatever prominent location your office decides to post the notice]. You have a right to receive a copy of this notice, and all individuals receiving care will be given a hard copy

Acknowledgement:

I hereby acknowledge that I received a copy of this Notice of Privacy Practices.

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Patient Signature **Date**