The Center for Relational Change

Healing Hearts | Empowering Minds | Restoring Spirits

www.CenterforRelationalChange.com

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HIPAA Notice of Privacy Practices & Authorization Form

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

Purpose: Effective April 14, 2003, all of the ways in which your protected medical information may be used, disclosed, or accessed is regulated by a new federal law called the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA seeks both to safeguard your medical information and to foster your knowledge and consent regarding those instances in which it may be shared with others. For these reasons, the Center for Relational Change is required to provide you with this summary of HIPAA regulations as they relate to any information that The Center for Relational Change gains, or medical records that it compiles, about your physical or mental health. HIPAA uses the general term "medical information" to describe these types of information. The following material will do likewise, even though The Center for Relational Change is not primarily a "medical" center.

Preface: It is important to note that The Center for Relational Change's overall privacy policy is to guard carefully the confidentially of your medical information, disclosing only that which is authorized by law to facilitate treatment and related healthcare operations, and to obtain payment for services. Moreover, it is The Center for Relational Change's practice to keep its clients fully informed about the nature, extent, and purpose of any medical information that is disclosed for these purposes.

The Center for Relational Change's Therapeutic Agreement and Consent to Treatment form describes the limited ways in which your medical information is likely to be used by clinicians at The Center for Relational Change. In contrast, the following material fulfills HIPAA's requirement of informing you of all of the ways in which your medical information lawfully could be used if a provider chose to do so. **There are four main headings: (1) Uses and disclosures of medical information that do not require your specific consent; (2) Uses and disclosures to which you can object; (3) Uses and disclosures that require your prior written consent; and (4) Your rights concerning your protected medical information.**

Please do not hesitate to ask about anything in this Notice. Any related concerns or complaints can be discussed. You also have the right to file a written complaint with the secretary of the U.S. Department of Health and Human Services.

The Center for Relational Change reserves the right to modify its Notice of Privacy Practices as state and federal regulations change, or when doing so would enhance the overall quality of its services. You would be notified in advance of any important changes and may request a copy of an updated Notice at any time. It also will be posted in the waiting room.

USES AND DISCLOSURES OF MEDICAL INFORMATION THAT

DO NOT REQUIRE YOUR SPECIFIC CONSENT

(although it is The Center for Relational Change's practice to gain written consent whenever possible)

Uses and Disclosures of Medical Information Relating to Treatment, Payment, and Healthcare Operations

1. **For Treatment:** With the possible exception of information concerning drug and alcohol abuse and/or treatment and HIV status (which may require specific authorization), your medical information may be disclosed to other healthcare providers who are, or might become, involved in your care. For example, your medical information may be disclosed to a hospital if you ever should be in need of medical attention while at The Center for Relational Change. Similarly, your medical information may be released to other providers to whom you might be referred for treatment or evaluation. The purpose of such disclosure is to coordinate as effectively as possible your overall healthcare.

2. **For Payment:** With the possible exception of information concerning drug and alcohol abuse and/or treatment and HIV status (which may require specific authorization), the medical information that is necessary for billing and collecting any third-party payments that you have authorized may be so used and disclosed. Common third-party payer services include: your health insurance company and related managed-care entities, Medicaid or Medicare, and State and County Mental Health/Mental Retardation funding.

3. **For Healthcare Operations:** Medical information that enhances and contributes to the overall running of a healthcare organization may be used and disclosed. For example, a clinician at The Center for Relational Change might use your medical information to evaluate the quality of his programs and services, or to insure that his operations are in compliance with state and federal regulations and laws. If such information concerns mental health disorders and/or treatment, drug and alcohol abuse and/or treatment, and HIV status, further restrictions on disclosure might apply and specific authorization may be required.

A. Other Uses and Disclosures of Medical Information Permitted by Federal Law (and not requiring your specific consent)

1. **When a Disclosure is Required by Law (Federal, State, or Local), in Legal Proceedings, or by Law Enforcement.** For example, a clinician at The Center for Relational Change may disclose your medical information if ordered to do so by the court, or when mandated to do so by law—as in cases of gunshot wounds, dog bites, life-threatening actions or intent, or suspected child abuse.

2. **For Public Health Activities**. The law mandates the reporting of information about certain diseases, as well as any deaths, to authorized government agencies. With the possible exception of information

concerning mental health disorders and/or treatment, drug and alcohol abuse and/or treatment, and HIV status (which may require specific authorization), certain aspects of your medical information may be provided to the coroner or a funeral director.

3. **For Health Oversight Activities**. For example, your medical information may be provided to authorized representatives from the state and county agencies that regulate The Center for Relational Change programs and seek to ensure the quality of its services.

4. **For Organ Donation**. If you wish to make an eye, an organ, or tissue donation upon your death, certain necessary medical information may be disclosed to assist appropriate organ procurement organizations.

5. **For Research Purposes.** In certain limited circumstances (for example, where federally approved by an appropriate Privacy Board or Institutional Review Board), your medical information may be used for a research study.

6. **To Avoid Harm.** If a counselor or physician believes in good faith that you, another person, or the public as a whole is in danger of being harmed and is in need of protection, he or she may release related medical information to the police or others who might be able to prevent or lessen the possible harm.

7. **For Specific Government Functions.** With the possible exception of information concerning drug and alcohol abuse and/or treatment and HIV status (which may require specific authorization) the medical information of military personnel or veterans may be disclosed to appropriate U.S. military authorities. Similarly, medical information may be disclosed for national security purposes.

8. **For Workers' Compensation.** If, as a result of a workplace injury, you are seeking workers' compensation, your medical information may be disclosed under the conditions described by workers' compensation law.

USES AND DISCLOSURES OF MEDICAL INFORMATION TO WHICH YOU HAVE A RIGHT TO OBJECT

A. **Appointment Reminders and Notification of Health-Related Benefits or Services.** Unless you specifically object, your medical information may be used to provide you with appointment reminders or to give you information about alternative programs and treatments that could be of help to you. If you do not wish to be so contacted, please call The Center for Relational Change at 412-301-4221.

B. **Fundraising Activities.** Although it is not The Center for Relational Change's practice to do so, an organization may use the medical information it has about you to contact you as part of its fundraising activities or those of other charitable causes or community-health programs with which it might be involved. The Center for Relational Change will not contact you for such fundraising activities, unless you specifically request us to do so.

C. **Disclosure to Family, Friends or Others Involved in Your Care.** Unless you specifically object, a limited amount of your medical information can be provided to a family member, friend, or other person known to be involved in your care or in its payment. For example, if a family member attends a counseling session with you, otherwise protected medical information may be disclosed to him or her unless you specifically prohibit it. (This does not include information about drug and alcohol abuse and/or treatment and HIV status, which requires your specific authorization).

D. **Disclosures to Notify a Family Member, Friend, or Other Selected Person in Cases of Emergency**. In case of medical emergency, and unless you specifically object, limited medical information (such as your location and general condition, etc.) may be disclosed to your designated contact person, or to an available family member. (This does not include information about drug and alcohol abuse and/or treatment and HIV status, which requires your specific authorization).

USES AND DISCLOSURES OF MEDICAL INFORMATION THAT REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

A. Your specific written authorization is required to disclose medical information concerning drug and alcohol abuse and/or treatment and HIV status.

B. Beyond that permitted under federal law, clinicians at The Center for Relational Change will not release medical information without your signed authorization. Moreover, it remains the practice of the clinicians at The Center for Relational Change to obtain your written consent before disclosing your medical information, even in those instances permitted by law. If you choose to sign an authorization to disclose any of your medical information, you may revoke the authorization at any time and thereby stop further use and disclosure of that information. However, you must do so in writing.

YOUR RIGHTS CONCERNING YOUR PROTECTED MEDICAL INFORMATION

A. **The Right to Request Limits on the Uses and Disclosures of Your Medical Information.** You have the right to ask your therapist for specific limits on its use and disclosure of your medical information. Your therapist will cooperate as far as possible, but is not required to agree to such requests. If there is agreement, however, the restrictions will be binding. Please note that you are not permitted to limit those uses and disclosures that are required by law.

B. **The Right to Choose How The Center for Relational Change Sends Health Information to You or Contacts You.** You have the right to ask your therapist to contact you at an alternate address or telephone number (for instance, by sending information to your work address instead of your home address) or by alternate means (for example by email rather than by telephone). Your therapist must agree to your request as long as it is reasonably convenient.

C. **The Right to See, or to Obtain a Copy of, Your Medical Information.** In most cases, you have the right to look at, or to receive a copy of, your medical information. Such a request must be made in writing, and will be responded to within 30 days. In certain situations, your request may be denied. If it is, you will be

informed in writing of the reasons for the denial. In certain circumstances, you may have the right to appeal the decision.

If you request a copy of any portion of your medical information, you will be charged on a per page basis, according to Pennsylvania state law. Payment must be made in full before receiving the copied material. You also may ask your therapist to provide you with a summary or explanation of the medical information in question. There will be a reasonable charge for the preparation of the summary or explanation.

D. The Right to Receive a List of Certain Disclosures that you therapist has made of Your Medical Information. This list does not include: uses or disclosures for treatment, payment, or healthcare operations; disclosures to you or with your written authorization; or disclosures to your family for notification purposes or due to their involvement in your care. This list also does not include: disclosures made for national security purposes; disclosures to corrections or law enforcement authorities if you were in custody at the time; or disclosures made prior to April 14, 2003. Your requested list may not extend beyond a six (6) year period of disclosures.

Your request must be made in writing, and will be responded to within 60 days. The list that you receive will include: the date of the disclosure; the person or organization to whom the disclosure was made (with an address, if available); a brief description of the information disclosed; and a brief reason for the disclosure. The list will be provided to you at no charge.

E. The Right to Ask to Correct or to Update Your Medical Information. If you believe that there is a mistake in your medical information or that a piece of important information is missing, you have a right to ask for an appropriate change to the information. The request, along with the reason for making it, must be made in writing, and will be responded to within 60 days.

If the request is approved, the appropriate change will be made to your medical information, and you will be informed of the change, along with any others who also need to be informed.

Your request may be denied if the medical information: (1) is correct and complete, as is; (2) was not created by The Center for Relational Change; (3) is not allowed to be disclosed to you; or (4) is not part of The Center for Relational Change or your therapist's records. A written response will state the reasons for denial and explain your right to file a written statement of disagreement. You may ask your therapist to include a copy of your request form, along with your therapist's denial, with all future disclosures of the related medical information.

F. The Right to Obtain a Paper Copy of This Notice. If you have agreed to receive this Notice of Privacy Practice via email, you have the right to request a paper copy as well.

HIPAA Privacy Authorization Form

1. I hereby authorize _____ and
   (therapist name)
   affiliates to use and/or disclose the protected health information described below to
   _____
   (*Insert full name of individual, organization, and/or third party payer (ie. insurance company)*.

2. Authorization for Release of Information:
   a. □ I hereby **authorize the release of all past, present, and future periods of my complete health record** **OR**

   b. □ I hereby **authorize the release of all past, present, and future periods of my complete health record with the exception of the following information**:

      □ Mental health records

      □ Communicable diseases (including HIV and AIDS)

      □ Alcohol/drug abuse treatment

      □ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. This authorization for release of information shall be in force and effect until _____ (Date of Event), at which time this authorization expires.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Print Name of Client or Personal Representative Relationship to Client

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Print Name of Client or Personal Representative Relationship to Client