ST. LAWRENCE COUNTY COMMUNITY SERVICES

Mental Health, Addictions Services, Developmental Disabilities
80 State Highway 310, Suite 1, Canton, NY 13617-1493

315-386-2048 **FAX 315-386-2435**

NOTICE OF 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 READ IT CAREFULLY.

St. Lawrence County Community Services has adopted the following policies and procedures for protection of the privacy of the people we serve.

Our Obligation to You

The St. Lawrence County Community Services Department, which includes Mental Health and Chemical Dependency Services, respect your privacy. We are required by law to maintain the privacy of "protected health information (PHI)" about you, to notify you of our legal duties and your legal rights, and to follow the privacy policies described in this notice. "Protected health information (PHI)," means any information that we create or receive that identifies you and relates to your health or payment for services to you.

Use of Information Within Our Agency

When you are receiving therapy from us, other individuals other than your therapist/counselor may have access to your protected health information.

Here are some examples:

- The psychiatrist/physician must review and sign all assessments.
- A support staff person will type information in your chart.
- Billing staff will need information to bill your insurance company.

Generally, staff have access to only that information needed to perform their function, i.e. billing will have your diagnosis, type of service you received (group or individual therapy, medical evaluation).

Sign in Sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Disclosure outside our Agency

It is our policy to obtain your written consent to disclose your protected health information (PHI) outside of our agency. You will be asked to sign a Consent for Release of Information Form to permit all such disclosures of your information.

Examples are:

- To obtain records from other agencies that have provided you service. Only those needed to coordinate & provide comprehensive care to you will be requested.
- In order to bill your insurance company, we will need to provide diagnosis and the type of service you received. On occasion, insurance companies request your treatment plan or progress notes to justify continued service. We utilize a Collections' Attorney for bills that are ignored and no plan of payment is able to be negotiated. Only the name, address, service dates and amount owed are disclosed. Claims are processed in Small Claims Court. This is used very seldom and only when individuals refuse to even make a minimum payment on their account. Consent is signed as part of the billing policy. Occasionally, there is an overpayment and we must get your refund check by sending your name and the amount owed to you to the County Treasurer's Office.

Disclosures without Written Consent

Under certain circumstances, we will provide your protected health information (PHI) to others without your permission. This is limited to the minimum amount necessary.

Examples are:

- Emergencies: If there is an emergency, we will disclose your protected health information (PHI) as needed to enable people to care for you.
- Disclosure to health oversight agencies: We are legally obligated to disclose protected health information (PHI) to State Oversight agencies that are responsible for licensing our Clinics. During relicensing visits, they will review a sample of active records. In some instances, the information is provided without names, so that the State can have information for statistical purposes.
- Disclosures to child protection agencies: We are mandated to disclose protected health information (PHI) as needed to comply with state law requiring reports of suspected incidents of child abuse or neglect.

Other disclosures without written permission. Required by Law*

- Pursuant to a court order
- To law enforcement officials in the event of a serious crime
- To correctional institutions regarding inmates
- To federal officials for lawful military or intelligence activities
- To coroners and medical examiners
- Justice Center

The examples given above are only given for your information and rarely, if ever, happen. In each case, we would make an effort to inform you and receive your consent.

*Regarding Chemical Dependency Services: We will follow the provisions of 42 CFR Part 2 governing disclosure of protected health information (PHI). Except for the circumstances described above, we will not disclose protected health information to another party without your written permission of the individual or a court order. If a request for disclosure of your medical record is received, you will be contacted and asked whether or not you wish to authorize disclosure. If you refuse or cannot be reached we will not disclose information without a court order.

Your Legal Rights

Right to request confidential communications: You may request that communications to you, such as appointment reminders, bills, or explanations of health benefits be made in a confidential manner. We will accommodate any such request, as long as you provide a means for us to process payment transactions.

Right to request restrictions on use and disclosure of your information: You have the right to request restrictions on our use of your protected health information (PHI) for particular purposes, or our disclosure of that information to certain third parties. At your request, we will not disclose information about your care that you have paid for out-of-pocket to health plans, unless for treatment purposes or in the rare event the disclosure is required by law. In other circumstance, we are not obligated to agree to a request restriction, but we will consider your request. We are not obligated to agree to a requested restriction, but we will consider your request.

Right to revoke a Consent for Release of Information: You may revoke a written Consent or Authorization for us to use or disclose your protected health information (PHI). The revocation will not affect any previous use or disclosure of your information.

Right to review and copy records: You have the right to see records used to make decisions about you. We will allow you to review your records unless a clinical professional determines that would create a substantial risk of physical harm to you or someone else. If another person provided information about you to our clinical staff in confidence, that information may be removed from the record before it is shared with you. We will also delete any protected health information (PHI) about other people. Decisions on access to your record will be made within 10 business days.

At your request, we will make a copy of your record for you. We will provide access to your electronic health record (EHR) and other electronic records in the electronic form or format requested by you if the records are readily reproducible in that format. Otherwise, we will provided the records in another mutually agreeable electronic format or hardcopy format. There is a reasonable fee for this service.

Right to "amend" record: If you believe your records contain an error, you may ask us to amend it. If there is a mistake, a note will be entered in the record to correct the error. If not, you will be told and allowed the opportunity to add a short statement to the record explaining why you believe the record is inaccurate. This information will be included as part of the total record and shared with others if it might affect decisions they make about you.

Right to an accounting: You have the right to an accounting of some disclosures of your protected health information (PHI) to third parties. This does not include disclosures that you authorize, or disclosures that occur in the context of treatment, payment or health care operations. We will provide an accounting of other disclosures made in the preceding six years. If requested by law enforcement authorities that are conducting a criminal investigation, we will suspend accounting of disclosures made to them.

How to Exercise Your Rights

Questions about our policies and procedures, requests to exercise individual rights and complaints should be directed to the agency contact.

Coordinator of Mental Health and Chemical Dependency Services, 386-2167

Personal Representatives: A "personal representative" of a patient may act on their behalf in exercising their privacy rights. This includes the parent or legal guardian of a minor. In some cases, adolescents who are "mature minors" may make their own decisions about receiving treatment and disclosure of protected health information (PHI) about them. If an adult is incapable of acting on his or her own behalf, the personal representative would ordinarily be his or her spouse or another member of the immediate family.

Disclosure of protected health information (PHI) to personal representatives may be limited in cases of domestic or child abuse.

Complaints

If you have any complaints or concerns about our privacy policies or practices, please submit a Complaint to our Contact Person. If you wish, the contact person, identified in the previous section, will give you a form that you can use to submit a Complaint.

You can also submit a complaint to the United States Department of Health and Human Services. Send your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20202
OCR Hotlines – Voice: 1-800-368-1019

We will never retaliate against you for filing a complaint. You will not be penalized in any way for filing a complaint.

Effective Date
The Community Services Board approved these original policies and procedures on March 18, 2003. They are effective as of April 14, 2003.
HIPAA notice of privacy practices) Revised and updated effective September 23, 2013 based on HIPAA/HITECH and Omnibus Final Rule.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been offered and/or received a copy of the Notice of Privacy Practices of St. Lawrence County Community Services.

_____ _____

Signature Date

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Print Name