Family Service Association of Bucks County

Stronger today. Brighter tomorrow.

NOTICE OF PRIVACY PRACTICES

This notice describes how protected information (sometimes referred to as Protected Health Information, Protected Information, Personal Information and/or Confidential Information) about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

Your Rights

When it comes to your information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• For programs that keep records, you may submit a request in writing to see or get an electronic or paper copy of your record and other information we have about you. Ask us how to do this. • The agency does not keep psychotherapy notes. • We will provide a copy or summary of your information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial. In certain circumstances, you may have a right to appeal the decision.
Ask us to correct your medical record	• For programs that keep records, you may submit a request in writing to us to correct information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 30 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • You can ask us **not** to provide you with appointment reminders. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain information for treatment or service, payment, or our operations.
	  ◦ We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  ◦ We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared your information	• You may submit a request in writing for a list (accounting) of the times we've shared your information, who we shared it with, and why. You may request this information for six years prior to the date you ask. • The list we provide will not include when we shared your information for treatment purposes, payment, and health care operations. It will not include when we shared information when you have asked us to (by signing a written authorization). We will provide one list per year for free, but we will charge a reasonable, cost-based fee if you ask for more than one per year.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly. **You may view and obtain an electronic copy of this notice on our website at <u>www.fsabc.org</u>**
To be notified of a breach of your information	• We will notify you if your protected information has been breached in any way.

Electronic Communication

Family Service staff are trained to limit electronic communication and/or to use encryption services wherever possible. If you choose to communicate electronically with your service provider (email, cell phones etc.) please be aware there are security risks and take precautions to protect personal information.

Complaints about your rights or our Privacy Practices?

If you have any questions about anything discussed in this Notice, about any of our privacy practices, or if you have any concerns or complaints, please contact our:

Privacy Officer
Family Service Association of Bucks County
4 Cornerstone Drive
Langhorne, PA 19047
Tel. (215) 757-6916

You also have the right to file a written complaint with the Secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1-877-696-6775 or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints**. We may not take any retaliatory action against you if you lodge any type of complaint.

Your Choices

For certain information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us in writing to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • We may not disclose information about mental health disorders and/or treatment, drug & alcohol abuse and/or treatment, and HIV status without your specific written authorization UNLESS you voluntarily consent to participate in family or group treatment session with others present. • If you are a minor, we may disclose information to your parent/guardian. Under the state Mental Health Procedures Act, a parent/guardian may attend a minor's treatment session without the minor's specific permission. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information:	• Marketing purposes. • Sale of your information.
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How we typically use or share your information
We typically use or share your information in the following ways:

To treat you	• We can use your information and share it with other professionals who are providing services to you (see previous page about your choices).	*Example:* A psychiatrist treating you asks another doctor about your overall health condition. *Example:* A case manager asks your primary care doctor about your overall health condition.
To run our agency	• We can use and share your information to run our agency, improve your care, and contact you when necessary. Most people that we share information with are themselves bound by professional ethics to maintain confidentiality.	*Example:* We use information about you to manage your treatment and services.
To receive payment for your treatment or service	• We can use and share your health information to bill and get payment from health plans or other organizations.	*Example:* We give information about you to your health insurance plan so it will pay for your treatment or service.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see **www.hss.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

Help with public health and safety issues	• We can share information about you for certain situations such as: • Preventing disease. • Helping with product recalls. • Reporting adverse reactions to medications. • Reporting suspected abuse, neglect, or domestic violence. • Reporting to agencies that collect information about deaths. We can share information with a coroner, medical examiner, or funeral director. • Presenting or reducing a serious threat to yours or anyone else's health or safety.
Do research	• We can use or share your information for research. Our Agency policy is to inform clients in advance and in writing before they enter any formal research study. In doing so, we routinely obtain a client's written authorization and consent to participate in such a study. Clients always have a right to refuse to participate in research. Clients who refuse to participate in research are not denied Agency services for which they otherwise are eligible.

Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donations requests	• We can share health information about you with organ procurement organizations.
Address worker's compensation, law enforcement and other government requests	• We can use or share information about you: • For workers' compensation claims. • For law enforcement purposes or with a law enforcement official. • With health oversight agencies for activities authorized by law. • For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share information about you in response to a court or administrative order, or in response to a subpoena.

Our Agency's policies and procedures are very strict in protecting your privacy and confidentiality. With relatively few exceptions, we require your written permission (Authorization) to disclose your health information.

There are other special protections for information concerning:

- Mental Health disorders and/or treatment,
- Drug and Alcohol abuse and/or treatment, and
- HIV-related information.
- The Bucks County Emergency Homeless Shelter and Housing Link. These programs follow the protocols established by the **Pennsylvania Homeless Management Information System (PA HMIS)**.

We may not disclose protected health information about mental health disorders and/or treatment, drug & alcohol abuse and/or treatment, and HIV status without your specific written authorization UNLESS you voluntarily consent to participate in family or group treatment session with others present.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, posted in our office, and on our web site.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

Client's Full Legal Name: ____ ____/____/____
Last *First* *Middle* *Date of Birth*

- I have received a copy of Family Service Association's **Notice of Privacy Practices**, which I understand provides a more complete description of possible uses and disclosures of my information.
- I understand that it is my right to review the Notice prior to signing this form.
- I understand that the terms of the Notice may change in the future.
- I understand that I may obtain a copy of the Notice that is in effect at any given time (whether or not it has ever been changed) by requesting a copy.

Please check one box: ❑ Client has accepted a copy. ❑ Client has declined a copy.

____ ___________________________
Client or Legal Representative Signature Date in own handwriting

____
Printed Name of Client or Legal Representative

If you are the legal representative of the client, please check off the basis for your authority:

❑ Parent of Minor ❑ Guardianship Order (attach copy) ❑ Power of Attorney (attach copy)

❑ Other ____________________________________

____ ___________________________
Staff Witness Signature Date in own handwriting

____
Print Staff Witness' name and Title