

# 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 REVIEW IT CAREFULLY.**

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**THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS MAINTAINED BY CLINTON COUNTY ALCOHOLISM SERVICES IS PROTECTED BY FEDERAL LAW AND REGULATIONS. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION.** All employees, volunteers, staff, doctors, health professionals, and other personnel are legally required to abide by the policies set forth in this Notice and to protect the privacy of your health information.

**This "protected health information" includes information that can be used to identify you. We collect or receive this information about your past, present or future health condition to provide health care to you or to receive payment for this health care.** We must provide you with this Notice about our privacy and confidentiality practices that explains how, when and why we use and disclose (release) your Protected Health Information. We may not use or release any more of your Protected Health Information than is necessary to accomplish the need for the information. We must abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes to this Notice will apply to Protected Health Information already in existence. Before we make any change to our policies, we will promptly change this Notice and post a new Notice in our lobby. You can also request a copy of this Notice from our privacy official at anytime and can view a copy of the Notice on our Web site at [http://www.clintoncountygov.com/Departments/MHAS/ASHIPA\\_A.html](http://www.clintoncountygov.com/Departments/MHAS/ASHIPA_A.html).

Generally, we 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, **UNLESS:**

1. You consent in writing.
2. The disclosure is required by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

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**WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION** for many different reasons. Below, we describe the different categories of when we use and release your Protected Health Information **without your consent.**

## **A. WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT OR HEALTH CARE OPERATIONS.**

**1. For Treatment.** We may share your Protected Health Information among physicians, nurses, psychologists, social workers, interns, and other health care personnel who are directly involved in your health care at this clinic. **For example:** Your primary therapist and your medication provider will share your protected health information to provide the best care for you. For external disclosures we will always ask for your consent before we disclose your health information.

**2. To obtain payment for treatment.** We may use and release your Protected Health Information in order to bill and collect payment **from you** for services provided to you. It is important that you provide us with correct and up-to-date information. **For example:** We may release portions of your Protected Health Information to our billing department to get paid for the health care services we provided to you. We may also release your Protected Health Information to our business associates, such as billing companies and collection agencies.

**3. To run our health care business.** We may use your Protected Health Information internally, in order to operate our facility in compliance with healthcare regulations. **For example:** We may use your Protected Health Information to review the quality of our services and to evaluate the performance of our staff in caring for you.

## **B. WE DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PROTECTED HEALTH INFORMATION FOR THE FOLLOWING:**

**1. When federal, state, or local law; or judicial or administrative proceedings require the disclosure of your Protected Health Information.** We release your Protected Health Information when a law requires or allows us to report information. When we receive a court order **and** a subpoena we are compelled to disclose Protected Health Information. **Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Local Authorities.** We would notify the New York State Child Abuse Registry about victims of child abuse or neglect. **Also, Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.**

**2. About Decedents.** We report information about deaths to the NY State Office of Alcoholism and Substance Abuse Services and the Quality of Care Commission. We provide coroners/medical examiners necessary information relating to an individual's death.

**3. For appointment reminders and health-related benefits and services.** We may use your demographic Protected Health Information to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

**4. For health oversight activities.** We may use and disclose your Protected Health Information to a health oversight agency, including the NY State Office of Alcoholism and Substance Abuse Services, Medicaid, Medicare, or your Health Insurance Plan, for oversight activities authorized by law, including audits, licensure, or other activities necessary for oversight of the health care system or disciplinary actions against our workforce.

## **C. YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY OF THE FOLLOWING AND FOR**

## **ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT INCLUDED ABOVE**

**1. To obtain payment from your health care plan for treatment.** Pending your signed consent we may use and release your Protected Health Information in order to bill and collect payment **from your health care plan or another third party** for services provided to you. It is important that you provide us with correct and up-to-date information. Your refusal to provide authorization to disclose for payment purposes will result in your being billed for the full cost of services. **For example:** We may release portions of your Protected Health Information to business associates, such as claims processing companies and others that process our health care claims.

**2. Information shared with family, friends or others.** We will only release your Protected Health Information to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care if you agree to the disclosure by signing an Authorization Form.

**3. To other health care providers for treatment purposes.** When other health care providers request your Protected Health Information we can not disclose that information without your written Authorization unless the disclosure is made due to a medical emergency.

We will ask for your written authorization before using or releasing any of your Protected Health Information. If you choose to Consent to the release of your Protected Health Information, you may later revoke that Consent in writing at any time. This will stop any future release of your Protected Health Information for the purposes you previously authorized.

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## **YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

**A. You Have the Right to Request a Restriction of Uses and Disclosures of Your Protected Health Information.** If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit Protected Health Information that we are legally required or allowed to release.

**B. You Have the Right to Choose How We Communicate Protected Health Information to You.** All of our communications to you are considered confidential. You have the right to ask that we send information to you at an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, by phone instead of by mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed onto you for payment.

**C. You Have the Right to See and Get Copies of Your Protected Health Information.** You must make the request in writing. We will respond to you within 10 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You have the right to have the denial reviewed. A different person will review your request and the denial. To receive a copy of the entire medical record or a summary you must pay for the cost in advance. If your request to see the medical information is approved, we will arrange this in

accordance with established clinic policy. Please submit all requests for this information to our **Privacy Official**.

**D. You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your Protected Health Information.** This list **will not** include: uses you have authorized; those for treatment, payment or operations; uses made for national security purposes, to corrections or law enforcement personnel; or made before April 14, 2003. We will respond within 60 days of receiving your request. The list will include dates when your Protected Health Information was released and why, to whom your Protected Health Information was released (including their address if known), and a description of the information released. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame. Please submit all requests for this information to our: **Privacy Official**.

**E. You have the Right to Correct or Update Your Protected Health Information.** Your request to correct or add information to your medical record and the reason for the request must be made in writing. We will respond within 60 days of receiving your request. If we deny your request, our written denial will state our reasons and explain your right to file a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or releases of your Protected Health Information. If we approve your request, we will make the change to your Protected Health Information, tell you that we have done it, and tell others that need to know about the change or amendment to your Protected Health Information. Please submit all requests for this information to our **Privacy Official**.

**F. You have the Right to Get This Privacy Notice.** You have the right to request another paper copy of this Notice at any time.

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**HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:** If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your Protected Health Information, you may file a complaint with the person listed below. You also may send a written complaint to the Secretary of the Department of Health and Human Services.

**You will not be penalized for filing a complaint.**

**PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:**

**Our Privacy Official:**

**Program Coordinator  
518-565-4060**

**Violation of Federal Law and regulations is a crime. Suspected Violations may be reported to the appropriate authorities in accordance with Federal regulations.** (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations)

**EFFECTIVE DATE OF THIS NOTICE**

This Notice is in effect as of April 14, 2003.