

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have been offered a copy of Trinity County Behavioral Health Notice of Privacy Practices for Protected Health Information and have been given the opportunity to review the notice prior to signing this form. Trinity County reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the terms of the Notice of Privacy Practices do change, I may obtain a copy of the revised Notice by contacting this facility at any time after the change or at the time of my next visit.

- I agree to uses and disclosures of my health information for the purpose of treatment, payment and operations, but request that some restrictions apply (see Access of Rights form).
- I agree to uses and disclosures of my health information for the purpose of treatment, payments and operations, but request that I be contacted by you at an alternative location or by alternative means (see Access of Rights form).

\_\_\_\_\_  
Print Name of Consumer

\_\_\_\_\_  
Signature of Consumer / Authorized Representative\*

\_\_\_\_\_  
Date

*\*Please indicate Representative's relationship to Consumer and include a description of Representative's Authority to act on behalf of the Consumer.* \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**Inability to Obtain Acknowledgement / Client Refused to Sign**

*Complete this section only if the client/consumer's signature is not obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## TRINITY COUNTY BEHAVIORAL HEALTH SERVICES NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact the program Privacy Officer. Trinity County Behavioral Health Services (TCBHS) is committed to protecting your personal health information and we want to assure you that we understand the sensitive and personal nature of the information provided to us during the course of your treatment. We also want to make you aware of how your protected health information here is used and stored.

In order to provide you with quality care and to comply with certain legal requirements, we create a record of the services you receive with us.

We are required by law to:

- Make sure that information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

The following categories describe different ways that we use and disclose your health information. We will provide you with examples of each category to help explain the purpose for the disclosure, but not every use or disclosure within that category will be listed. However, all of the ways we are permitted to use and disclose your information will fall within one of those categories. **Alcohol and Drug programs have very strict laws regarding privacy and you will notice that we have identified the areas where the laws are different from our Mental Health Services.**

- **Treatment**

We may use information about you to provide you with treatment or services. Information about you may be shared amongst TCBHS personnel involved in your treatment for the purpose of coordination of care between programs within TCBHS for referral and treatment purposes.

For Mental Health clients we may also share information with others outside TCBHS who will be involved in your care. The doctors, nurses, therapists, case managers, and other clinical staff involved in your care may share information about you in order to coordinate services or determine how to best meet your needs. For example, if you and your therapist believe that you may need assistance finding appropriate housing, a case management referral could be made and the case manager made aware of your particular needs. For Mental Health services, home visits may be part of the way services are delivered to you, and the doctors or nurses may need to share information about you with your pharmacy in order to get your prescriptions filled, or with a school nurse if medications ordered by us are to be dispensed during school hours. Staff may need to disclose information about you when making a referral to a psychiatric hospital should you require inpatient treatment, or in a psychiatric emergency as deemed necessary to protect the health and safety of you or others. For our Alcohol and Other Drug programs we will make these referrals only with your written consent, consistent with federal laws.

- **Payment**

If you are a client of one Mental Health program, we may use and disclose health information about you so that the treatment and services you receive here may be billed to and payment collected from you, an insurance company, or a third party. For example, we may be required to inform your health plan of what we are treating you for, what specific services you are receiving, and the dates of those services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval for services, if, for example, you should need hospitalization. For our Alcohol and Other Drug programs we will make these referrals only with your written consent, consistent with federal laws.

- **Health Care Operations**

We may use and disclose personal information about you for the clinic operations. These uses and disclosures are necessary to run the clinic and make sure all of our consumers receive quality care. For example, we may use information about you contained in your health record to review our treatment and services, and to evaluate the performances of staff in caring for you. We may also disclose information to those designated to review our procedures and practices to ensure we are in compliance with regulations and that the services we provide to you meet acceptable standards of care.

Generally, we may not say to a person outside of our program, who is not a provider of your health services or a representative of your health plan, that you attend our program, or disclose any information identifying you as a person who receives Mental Health or Alcohol and Drug Abuse treatment except when:

- 1) You authorize us to do so in writing.
- 2) The disclosure is allowed by a court order.
- 3) The disclosure is made to health care personnel in a medical or psychiatric emergency or to qualified personnel for audit, or program evaluation.
- 4) The disclosure is to report suspected child abuse or neglect.
- 5) The disclosure is to report a crime committed by a consumer either at the program or against any person who works for the program or about any threat to commit such a crime to local authorities

**In addition, for Mental Health clients we may disclose information when:**

- 6) The disclosure is to report suspected intention to physically harm another person to local authorities and the identified person targeted for harm.
- 7) The disclosure is to your parent, legal guardian, or conservator if you are a minor or conservatee and it would be detrimental to you not to disclose information about your treatment.
- 8) The disclosure is to report elder and/or dependent adult abuse, or neglect to local authorities.
- 9) In an emergency when we may be required to evaluate you and arrange for your involuntary hospitalization if it is believed you may be, as a result of a mental disorder, a danger to yourself, others, or unable to meet your basic needs of food, clothing, and shelter.
- 10) We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- 11) The disclosure is made to avert a serious threat to your health and safety or to the health and safety of others.
- 12) The disclosure is to report to the Department of Public Health the psychiatrist's opinion that your mental condition impairs your ability to drive.

**Appointment Reminders**

We may use and disclose limited information to contact you as a reminder that you have an appointment, to change an appointment, or to make contact with you should you fail to keep any of your appointments.

**Health Oversight Activities**

We may disclose health information about you to a health oversight agency for activities authorized by law. These oversight activities include, for example: audits, investigations, inspections, and licensure. These activities are necessary for Federal, State, and local governmental agencies to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes**

If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court order. For Drug and Alcohol clients any such court order must be obtained through 42 Code of Federal Regulations.

For our Mental Health clients, information may be released in response to a subpoena, discovery request, or other lawful request provided that:

- We have received a written statement and documentation showing that the requesting party has secured a court order, or;
- If subpoena is for a summons to court, we will appear in court with the information requested, but will not release it until the court has ordered us to do so.

**Law Enforcement**

We may release protected health information to a law enforcement official only under court order for our Alcohol and Other Drug clients. For our Mental Health and Work Experience clients we will release information:

- In response to a court order;
- About criminal activity at our program, or against any person who works for our program, or about any threat to commit such a crime;
- If we suspect that you intend to physically harm another person (and to the identified intended victim as well).

**Coroners or Medical Examiners**

We may release medical information to a coroner or medical examiner as authorized by law. This may be necessary, for example, to identify a deceased person or determine the cause of death.

### **National Security and Intelligence Activities**

We may release health information about you to authorized federal officials for national security activities as authorized by law.

### **Protected Services for the President and Others**

We may disclose health information about you to authorized federal officials so that they may provide protection to the President, other authorized persons or foreign heads of state, or conduct special investigations as authorized by law.

### **Inmates**

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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

You have the following rights regarding the health information we maintain about you:

### **Right to Inspect and Copy**

You have a right to inspect and copy your health information that may be used to make decisions about your care. There may be some exceptions to this right, such as when information requested contains specific identifying information about another person, or for mental health clients, when a licensed health care professional believes that the access of that information may endanger the life or physical safety of you or another person.

You further have a right to have any denial of access to your information reviewed by another licensed health care professional designated by this agency to review consumer complaints and who did not participate in the original decision to deny. We will comply with the outcome of this review.

To inspect and copy your health information, you must submit your request in writing to the facility where you receive care. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, compiling a summary, or other supplies associated with your request. The total cost will depend upon the number of pages you want to have copied and mailed. The information regarding the cost to you can be provided prior to copies being made.

### **Right to Amend**

If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request the amendment for as long as the information is kept by or for us.

To request an amendment, your request must be made in writing and submitted to the TCBHS facility where you are receiving care. In addition, you must provide a reason that supports your request.

We may deny your request if it is not made in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

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

### **Right to an Accounting of Disclosures:**

You have the right to an "accounting of the disclosures." This is a list of the disclosures we made of health information about you, other than for releases for which you provided written authorization, or for releases used for purposes of treatment, payment, and health care operations, as those functions are described above.

To request a list or accounting of disclosures, you must submit your request in writing to the TCBHS facility where you are receiving care. Your request must state the time period, which 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, electronically). The first list you request in a twelve-month period will be free. There may be a fee for any additional lists requested within a year. We will notify you of the costs 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 the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care.

*We are not required to agree to your requests.* If we do agree, we will comply with your requests unless the information is needed to provide you emergency treatment or as authorized by law.

To request restrictions, you must make your request in writing to the TCBHS facility where you are receiving care. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply. For example: disclosures to your spouse.

### **Right to Request Confidential Communications**

You have the right to request that we communicate with you about your health matters in a certain way 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 the TCBHS facility where you are receiving care. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

### **Right to a Paper Copy of This Notice**

You have a right to a copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a copy of this notice, contact the front desk at the TCBHS facility where you are receiving care.

### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for the health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the lobby of each TCBHS facility. The notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you open your case for services, we will offer you a copy of the current notice in effect.

### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with this program by asking to speak with the Program Privacy Officer at the TCBHS facility where you are receiving care, or with the Chief of Privacy for Trinity County at:

**Trinity County Behavioral Health Services**

**Attention: Chief of Privacy**

**P.O. Box 1640**

**Weaverville, CA 96093**

**(530) 623-1362**

You may also file a complaint with the Secretary of the Department of Health and Human Services.

**You will not be penalized, intimidated, threatened, coerced, discriminated, or retaliated against for filing a complaint.**

### **OTHER USES OF HEALTH INFORMATION**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have made with your permission, and that we are required to retain our records of the care that we provided to you.