HIPAA NOTICE OF PRIVACY PRACTICES FOR CHOICES, INC.

1231 Gambell Street, Suite 300, Anchorage, AK 99501
Phone: (907)333-4343 | FAX (907)333-4383
Our Administrative Hours: Mon – Fri | 9AM – 5PM

Effective September 3, 2019

Following is the CHOICES, Inc. Notice of Privacy Practices, explaining how we use and disclose protected health information, as well as how CHOICES, Inc. clients can obtain access to this information. CHOICES, Inc. takes the privacy of our client's protected health information very seriously. We are committed to ensuring that the confidential data we manage on your behalf stays that way.

OVERVIEW

Purpose — The purpose of this notice is to:

- ✓ Provide you with notice of CHOICES, Inc. information protection practices, and
- ✓ Explain your rights as a CHOICES, Inc client.

CHOICES, Inc. Responsibilities — CHOICES, Inc. is required to abide by the terms of this notice currently in effect by:

- ✓ maintaining the privacy of your Protected Health Information,
- ✓ notifying you of any breaches of your unsecured Protected Health Information, and
- ✓ providing you with notice of our legal duties and privacy practices with respect to Protected Health Information

Notice Revisions — CHOICES, Inc. reserves the right to revise the terms of this notice, and to make the revised terms effective for all Protected Health Information that it maintains. If CHOICES, Inc. revises this notice, we will make the revised notice available on our website and include information about the changes next time we meet in the office, as well as mailing a notification to the address we have on file.

DEFINITIONS

Business Associate — A person or entity that uses Protected Health Information to perform a service for CHOICES, Inc. These services include, but are not limited to:

- ✓ billing
- ✓ claim processing
- ✓ data entry

Health Care Operations — Activities related to CHOICES, Inc. operations, including but not limited to:

- ✓ quality assessment and improvement
- ✓ doctor performance evaluations
- ✓ fraud and abuse detection
- ✓ claim payment
- ✓ claim audits
- ✓ customer issue resolution

Payment — CHOICES, Inc. collection of insurance premiums or its determination and payment of claims.

Protected Health Information — Information relating to a CHOICES, Inc. client's past, present or future health or condition, the provision of health care to a CHOICES, Inc. client, or payment for the provision of health care to a CHOICES, Inc. client. Protected Health Information includes, but is not limited to:

- ✓ client name
- ✓ Social Security number/member ID
- ✓ service date
- ✓ diagnosis information
- ✓ claim information

Treatment — The provision, coordination or management of vision care and related services by one or more vision care providers.

Continued

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WHO WILL FOLLOW THIS NOTICE

This notice describes our hospital's practices and that of:

- ✓ Any CHOICES, Inc. care professional and administrative staff authorized to enter information into your record.
- ✓ All programs and units of CHOICES, Inc.
- ✓ Any member of a volunteer group we allow to help you while you are enrolled in services at CHOICES, Inc.
- ✓ All employees, staff and other personnel.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or care operations purposes described in this notice.

OUR PLEDGE REGARDING MENTAL HEALTH INFORMATION

We understand that information about your mental health treatment and related health care services is personal. We are committed to protecting this information about you. We create a record of the care and services you receive at CHOICES, Inc. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to your mental health information generated by the agency, whether made by administrative personnel, your treatment team or any collateral received from another agency. Other agencies may have different policies or notices regarding the use and disclosure of your mental health information created in their office or clinic. We are required by law to:

- ✓ Make sure that mental health information that identifies you is kept confidential (with certain exceptions);
- ✓ Give you this notice of our legal duties and privacy practices with respect to mental health information about you; and
- ✓ Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MENTAL HEALTH INFORMATION ABOUT YOU

The following sections describe different ways that we may use and disclose your PHI.
Some information; such as certain drug and alcohol information, HIV information, genetic information and mental health information is entitled to special restrictions related to its use and disclosure. **Not every use or disclosure will be listed**. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories. Other uses and disclosures not described in this Notice will be made only if we have your written authorization.

For Treatment: We may use or disclose information so that you can receive mental health treatment or other healthcare services. For example, we may disclose information your doctor, hospital or therapist needs to know to give you quality care and to coordinate your treatment with others helping with your care.
Example: A doctor treating you asks another doctor about your overall health condition.

For Operating Our Programs: We may use or disclose information in the course of our ordinary business as we manage our programs. For example, we may use your health information to contact you to provide information about appointments, health-related information and benefits and services. We may also review information we receive from your doctor, hospital, nursing home and other health care providers to review how our programs are working or to review the need for and quality of health care services provided to you.
Example: We use health information about you to manage your treatment and services.

For Law Enforcement Purposes and As Required by Legal Proceedings: We will disclose information to the police or other law enforcement authorities as required by court order.

For Public Health and Safety: We may disclose information to prevent serious threats to health or safety of a person or the public.

For Coroners, Funeral Directors and Organ Donation: We may disclose information to a coroner or medical examiner for identification purposes, cause of death determinations, organ donation and related reasons. We may also disclose information to funeral directors to carry out funeral-related duties.

For Payment: We may use or disclose information to pay for your treatment and other services. For example, we may exchange information about you with your doctor, hospital, nursing home, or another government agency to pay the bills for your treatment and services.
Example: We give information about you to your health insurance plan so it will pay for your services.

For Public Health Activities: We report public health information to other government agencies concerning such things as contagious diseases, immunization information, and the tracking of some diseases such as cancer.

For Government Programs: We may disclose information to a provider, government agency or other organization that needs to know if you are enrolled in one of our programs or receiving benefits under other programs such as the Workers' Compensation Program.

For National Security: We may disclose information requested by the federal government when they are investigating something important to protect our country.

For Research: We may disclose information for permitted research purposes and to develop reports. These reports do not identify specific people.

For Reasons Otherwise Required by Law: CHOICES, Inc. may use or disclose your protected health information to the extent that the use or disclosure is otherwise required by law. The use or disclosure is made in compliance with the law and is limited to the requirements of the law

SPECIAL SITUATIONS

Communicable Diseases: We are required to report certain communicable diseases to appropriate public health authorities such as sexually transmitted diseases, food poisoning and others. This reporting does not require your permission. NC 130A-143 provides that anything that identifies a patient as being infected with AIDS is confidential except for epidemiological purposes (information is deidentified) Disclosures of HIV/AIDS information must have the patient's specific consent.

Psychotherapy Notes: Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. We may use or disclose your psychotherapy notes, as required by law, or:

- ✓ For use by the originator of the notes
- ✓ In supervised mental health training programs for students, trainees, or practitioners
- ✓ By the covered entity to defend a legal action or other proceeding brought by the individual
- ✓ To prevent or lessen a serious and imminent threat to the health or safety of a person or the public
- ✓ For the health oversight of the originator of the psychotherapy notes
- ✓ For use or disclosure to coroner or medical examiner to report a patient's death
- ✓ For use or disclosure necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public
- ✓ For use or disclosure to the Secretary of DHHS in the course of an investigation

Mental health treatment: Information regarding your mental health treatment may be used by or disclosed to those who are providing you with treatment. It may also be disclosed to entities responsible for paying for your care, such as insurance companies, but only the amount of information necessary for payment purposes will be disclosed. We may also use or disclose mental health treatment information for purposes of program evaluation or research under limited circumstances. If you are a minor, your mental health treatment records may be released to your parent or guardian under certain circumstances. In an emergency, information regarding your mental health treatment may be used or disclosed in order to prevent someone, (including you) from, being harmed.

Alcohol and Substance Abuse Services: If you request and/or receive alcohol and/or drug abuse services from us, federal law generally requires that we obtain your written consent before we may disclose information that would identify you as a patient. There are some exceptions to this requirement. We may disclose information to members of our workforce as needed to coordinate your care, and to agencies or individuals that help us carry out our professional responsibilities in serving you. We may disclose information to medical personnel in a medical emergency

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

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

Get an electronic or paper copy of your medical record

- ✓ You can ask to see or get an electronic or paper copy of your medical record and certain other health information we have about you.
- ✓ We will provide a copy or a summary of your health information, usually within 30 days of your request.
- ✓ We may charge a reasonable, cost-based fee

Ask us to correct your medical record

- ✓ You can ask us to correct information about you in your medical record that you think is incorrect or incomplete by writing to the Privacy Officer at the end of this notice.
- ✓ We may say "no" to your request, but we'll tell you why in writing within 60 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.
- ✓ 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 health information for treatment, 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 information

- ✓ You can ask for a list of the times and with whom we've shared your health information for six years prior to the date you ask. We are not required to include disclosures for treatment, payment, and health care operations, and certain other disclosures. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

- ✓ You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- ✓ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- ✓ We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- ✓ You can complain if you feel we have violated your rights by contacting the Privacy Officer
- ✓ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights 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 will not retaliate against you for filing a complaint

IF YOU HAVE ANY QUESTIONS

Please feel free to call us at (907)333-4343 or email reception@choices-ak.org

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

Acknowledgement of Receipt of Information Practices Notice and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

Client Name (Last, First, Middle)	*Date of Birth*

A Notice of Privacy Practices (NPP) is provided to all CHOICES, Inc. client and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

By the way of my signature below, I hereby *(read and initial each of the following statements)*

☐ I acknowledge that I have read the foregoing and received a copy of the "Notice of Privacy Practices" (Version dated 09/3/2019) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.

☐ I understand that I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement

☐ I understand that this organization has the right to changes its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices

☐ I understand that as part of my care, this facility originates and maintains records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as

- ✓ a basis for planning my care and treatment
- ✓ a means of communication among the health professionals who may contribute to my healthcare;
- ✓ a source of information for applying my diagnosis and surgical information to my bill;
- ✓ a means by which a third-party payer can verify that services billed were actually provided
- ✓ a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

☐ I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Signature (Optional for Minors/Adults with Guariands)	*Name (Printed)*	*Date of Signature*
Personal Representative Signature	*Name (Printed)*	*Date of Signature*
Witness Signature	*Name (Printed)*	*Date of Signature*

For Internal Use Only

If applicable, reason patient's written acknowledgment could not be obtained:

☐ Client was unable to sign ☐ Client Refused to sign ☐ Other _____