Connections Behavioral Health & Complex Pain Recovery ®
900 Old Roswell Lakes Pkwy
Roswell, GA 30076
678-571-3065

Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PRIVACY PRACTICES

I. COMMITMENT TO YOUR PRIVACY: *YOUR NAME or YOUR PRACTICE NAME* is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that *YOUR NAME* maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

II. LEGAL DUTY TO SAFEGUARD YOUR PHI: By federal and state law, *YOUR NAME* is required to ensure that your PHI is kept private. This Notice explains when, why, and how *YOUR NAME* would use and/or disclose your PHI. Use of PHI means when *YOUR NAME* shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when *YOUR NAME* releases, transfers, gives, or otherwise reveals it to a third party outside of the *YOUR NAME*. With some exceptions, *YOUR NAME* may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, *YOUR NAME* is always legally required to follow the privacy practices described in this Notice.

III. CHANGES TO THIS NOTICE: The terms of this notice apply to all records containing your PHI that are created or retained by *YOUR NAME* Please note that *YOUR NAME* reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that *YOUR NAME* has created or maintained in the past and for any of your records that *YOUR NAME* may create or maintain in the future. *YOUR NAME* will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of *YOUR NAME's* Notice of Privacy Practices.

IV. HOW YOUR NAME MAY USE AND DISCLOSE YOUR PHI: *YOUR NAME* will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the "Information, Authorization and Consent to Treatment" document. Below you will find the different categories of possible uses and disclosures with some examples.

1. For Treatment: *YOUR NAME* may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are; otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, *YOUR NAME* may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, *YOUR NAME* will always ask for your authorization in writing prior to any such consultation.

2. For Health Care Operations: *YOUR NAME* may disclose your PHI to facilitate the efficient and correct operation of its practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

3. To Obtain Payment for Treatment: *YOUR NAME* may use and disclose your PHI to bill and collect payment for the treatment and services *YOUR NAME* provided to you. Example: *YOUR NAME* might send your PHI to your insurance company or managed health care plan in order to get payment for the health care services that have been provided to you. *YOUR NAME* could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for *YOUR NAME's* office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, *YOUR NAME* will always do its best to reconcile this with you first prior to involving any outside agency.

4. Employees and Business Associates: There may be instances where services are provided to *YOUR NAME* by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, *YOUR NAME* will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of *YOUR NAME*.

Note: This state and Federal law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health and AIDS/HIV,** and may limit whether and how *YOUR NAME* may disclose information about you to others.

V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – YOUR NAME may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **Law Enforcement:** Subject to certain conditions, *YOUR NAME* may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: *YOUR NAME* may make a disclosure to the appropriate officials when a law requires *YOUR NAME* to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **Lawsuits and Disputes:** *YOUR NAME* may disclose information about you to respond to a court or administrative order or a search warrant. *YOUR NAME* may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. *YOUR NAME* will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.
3. **Public Health Risks:** *YOUR NAME* may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.
4. **Food and Drug Administration (FDA):** *YOUR NAME* may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. **Serious Threat to Health or Safety:** *YOUR NAME* may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if *YOUR NAME* determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, *YOUR NAME* may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.
6. **Minors:** If you are a minor (under 18 years of age), *YOUR NAME* may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.
7. **Abuse and Neglect:** *YOUR NAME* may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If *YOUR NAME* has a reasonable suspicion of child abuse or neglect, *YOUR NAME* will report this to the Georgia Department of Child and Family Services.
8. **Coroners, Medical Examiners, and Funeral Directors:** *YOUR NAME* may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. *YOUR NAME* may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.
9. **Communications with Family, Friends, or Others:** *YOUR NAME* may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, *YOUR NAME* may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.
10. **Military and Veterans:** If you are a member of the armed forces, *YOUR NAME* may release PHI about you as required by military command authorities. *YOUR NAME* may also release PHI about foreign military personnel to the appropriate military authority.
11. **National Security, Protective Services for the President, and Intelligence Activities:** *YOUR NAME* may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.
12. **Correctional Institutions:** If you are or become an inmate of a correctional institution, *YOUR NAME* may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others

13. **For Research Purposes:** In certain limited circumstances, *YOUR NAME* may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.
14. **For Workers' Compensation Purposes:** *YOUR NAME* may provide PHI in order to comply with Workers' Compensation or similar programs established by law.
15. **Appointment Reminders:** *YOUR NAME* is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.
16. **Health Oversight Activities:** *YOUR NAME* may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess *YOUR NAME*'s compliance with HIPAA regulations.
17. **If Disclosure is Otherwise Specifically Required by Law.**
18. **In the Following Cases, *YOUR NAME* Will Never Share Your Information Unless You Give us Written Permission:** Marketing purposes, sale of your information, most sharing of psychotherapy notes, and fundraising. If we contact you for fundraising efforts, you can tell us not to contact you again.

VI. Other Uses and Disclosures Require Your Prior Written Authorization: In any other situation not covered by this notice, *YOUR NAME* will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying *YOUR NAME* in writing of your decision. You understand that *YOUR NAME* is unable to take back any disclosures it has already made with your permission, *YOUR NAME* will continue to comply with laws that require certain disclosures, and *YOUR NAME* is required to retain records of the care that its therapists have provided to you.

VII. RIGHTS YOU HAVE REGARDING YOUR PHI:

1. The Right to See and Get Copies of Your PHI either in paper or electronic format: In general, you have the right to see your PHI that is in *YOUR NAME*'s possession, or to get copies of it; however, you must request it in writing. If *YOUR NAME* does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from *YOUR NAME* within 30 days of receiving your written request. Under certain circumstances, *YOUR NAME* may feel it must deny your request, but if it does, *YOUR NAME* will give you, in writing, the reasons for the denial. *YOUR NAME* will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. *YOUR NAME* may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask that *YOUR NAME* limit how it uses and discloses your PHI. While *YOUR NAME* will consider your request, it is not legally bound to agree. If *YOUR NAME* does agree to your request, it will put those limits in writing and abide by them except in emergency situations. 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. You do not have the right to limit the uses and disclosures that *YOUR NAME* is legally required or permitted to make.

3. The Right to Choose How *YOUR NAME* Sends Your PHI to You: It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). *YOUR NAME* is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

4. The Right to Get a List of the Disclosures. You are entitled to a list of disclosures of your PHI that *YOUR NAME* has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security

purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003.

YOUR NAME will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. *YOUR NAME* will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to 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.

6. The Right to Amend Your PHI: If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that *YOUR NAME* correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of *YOUR NAME's* receipt of your request. *YOUR NAME* may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than *YOUR NAME*. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and *YOUR NAME's* denial will be attached to any future disclosures of your PHI. If *YOUR NAME* approves your request, it will make the change(s) to your PHI. Additionally, *YOUR NAME* will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by Email: You have the right to get this notice by email. You have the right to request a paper copy of it as well.

7. Submit all Written Requests: Submit to *YOUR NAME's* Director and Privacy Officer, _____, at the address listed on top of page one of this document.

VIII. COMPLAINTS: If you are concerned your privacy rights may have been violated, or if you object to a decision *YOUR NAME* made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. *YOUR NAME* will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Please discuss any questions or concerns with your therapist. Your signature on the "Information, Authorization, and Consent to Treatment" (provided to you separately) indicates that you have read and understood this document.

IX. *YOUR NAME's* **Responsibilities:** We are required by law to maintain the privacy and security of your PHI. 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.

Date of Last Revision: 10/23/14