WARREN-WASHINGTON ASSOCIATION FOR MENTAL HEALTH, INC. (WWAMH)

NOTICE OF PRIVACY PRACTICES

Effective Date – April 14, 2003

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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of WWAMH staff and affiliated health care providers that jointly provide health care services with our programs. A copy of our current notice will always be posted in our reception area. You or your personal representative may also obtain a copy of this notice by accessing our website at wwamh.org or requesting a copy from our program staff.

If you have any questions about this notice or would like further information, please contact one of the following individuals:

Residential Services Director – Frank Molinari (518-747-2284)
Clinical Services Director – Linda Donovan (518-747-8243)
Support Services Director – Belinda Bradley (518-747-0035)
WWAMH Director - Peter Groff (518-747-2284)

WHO WILL FOLLOW THIS NOTICE?

WWAMH provides health care jointly with physicians and other health care professionals and organizations. The privacy practices described in this notice will be followed by:

- Any health care professional or other treatment provider who treats you at any of our locations;
- All employees, health care professionals, trainees, students or volunteers at any of our locations;
- All employees, health care professionals, trainees, students or volunteers that are part of an organized health care arrangement with our programs;
- Any business associates of our programs.

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PERMISSIONS DESCRIBED IN THIS NOTICE

This notice will explain the different types of permission we will obtain from you before we use or disclose your health information for a variety of purposes. The three types of permissions referred to in this notice are:

- A "general written consent," which we must obtain from you in order to use and disclose your health information in order to treat or care for you, obtain payment for that treatment or care, and conduct our business operations. We must obtain this general written consent the first time we provide you with treatment or care. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or care to you.

- An "opportunity to object," which we must provide to you before we may use or disclose your health information for certain purposes. In these situations, you will have an opportunity to object to the use or disclosure of your health information in person, over the phone, or in writing.

- A "written authorization," which will provide you with detailed information about the persons who may receive your health information and the specific purposes for which your health information may be used or disclosed. We are only permitted to use and disclose your health information described on the written authorization in ways that are explained on the written authorization form you have signed. A written authorization will have an expiration date.

IMPORTANT SUMMARY INFORMATION

Requirement for Written Authorization. We will generally obtain your written authorization before using your health information or sharing it with others outside the WWAMH programs. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke an authorization, please write to your Program Director listed on Page 1.

Exceptions to Written Authorization Requirement. There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

- **Exception for Treatment, Payment, and Business Operations.** We will obtain your general written consent one time to use and disclose your health information to treat or care for your condition, collect payment for that treatment or care, or run our business operations. In some cases, we also may disclose your health information to another health care provider or payor for its payment activities and certain of its business operations.

- **Exception for Directory Information and Disclosure to Family and Friends Involved In Your Care.** We will ask you whether you have any objection to including information about you in our Facility Directory or sharing information about your health with your friends and family involved in your care.

- **Exception in Emergencies or Public Need.** We may use or disclose your health information in an emergency or for important public needs. For example, we may share your information with public health officials at the New York State or city health departments who are authorized to investigate and control the spread of diseases.

- **Exception If Information Is Completely or Partially De-Identified.** We may use or disclose your health information if we have removed any information that might identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" information if the person who will receive the information agrees in writing to protect the privacy of the information.

How to Access Your Health Information. You generally have the right to inspect and copy your health information.

How to Correct Your Health Information. You have the right to request that we amend your health information if you believe it is inaccurate or incomplete.

How to Identify Others Who Have Received Your Health Information. You have the right to receive an "accounting of disclosures" which identifies certain persons or organizations to whom we have disclosed your health information in accordance with the protections described in this Notice of Privacy Practices. Many routine disclosures we make will not be included in this accounting, but the accounting will identify many non-routine disclosures of your information.

How to Request Additional Privacy Protections. You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement.

How to Request More Confidential Communications. You have the right to request that we contact you in a way that is more confidential for you. We will try to accommodate all reasonable requests.

How Someone May Act On Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

How to Learn About Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information. Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected. To request copies of these other notices now, please contact your Program Director listed on Page 1.

How to Obtain a Copy of This Notice. You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. To do so, please call your Program Director listed on Page 1. You or your personal representative may also obtain a copy of this notice from our website at wwamh.org, or by requesting a copy from our staff.

How to Obtain a Copy of Revised Notice. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your health information. We will post any revised notice in our reception areas. You or your personal representative will also be able to obtain your own copy of the revised notice by accessing our website at wwamh.org, or requesting a copy from our program staff. The effective date of the notice will always be noted on the first page. We are required to abide by the terms of the notice that is currently in effect.

How to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with HHS, you may contact them at 200 Independence Avenue, SW, Washington, D.C. 20201, or at 1-877-696-6775. In addition, the Federal Center for Deaf and Hearing Impaired can be contacted at 1-800-877-8339.

To file a complaint with us, please contact your Program Director listed on Page 1. *No one will retaliate or take action against you for filing a complaint.*

How to Obtain More Detailed Information. A manual providing more detailed information of WWAMH privacy practices is available to you. If you would like to receive this information, please ask staff for a copy of the WWAMH Privacy Manual.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the programs and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

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Signature of Client or Personal Representative

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Print Name of Client or Personal Representative

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Date

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Description of Personal Representative's Authority

By signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the program, its staff, and the facilities listed at the beginning of this notice.

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Signature of Client or Personal Representative

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Print Name of Client or Personal Representative

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Date

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Description of Personal Representative's Authority