ARA
Specialists in Human Services
Since 1982

NOTICE OF PRIVACY INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG & ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. PURPOSE OF THE NOTICE.

ARA is committed to preserving the privacy and confidentiality of your health information. Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 USC §130d et. Seq., 45 CFR Parts 160 & 164) and the Confidentiality Law (42 USC § 290dd-2, 42 CFR Part 2). State and federal laws and regulations require us to establish policies and procedures to protect the privacy of your health information, which includes any information that relates to your past, present or future health/mental health condition (which might include your photograph) may be used and released by ARA for the purposes of providing treatment to you. This Notice will provide you with information about our privacy practices toward all of your health information created and/or maintained at this office, including any information that we receive from other health care providers or facilities. The Notice describes the ways in which we may use or disclose (share) your health information and also describes your rights and our responsibilities concerning such uses or disclosures.

We will abide by the terms of this Notice, including any future revisions that we may make to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised or changed Notice effective for 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, which will identify its effective date, in our program waiting areas.

The privacy practices described in this Notice apply to:

1. Program staff for the purposes of providing treatment, maintaining the clinical record, staff supervision, incident reporting, medication administration, billing operations, and other treatment related processes;
2. Business Associates such as laboratories (blood work, urinalysis), and agencies that provide on-site delivery services, and;
3. Reporting to the NYS OASAS Client Data System, only if you are enrolled in our alcoholism/substance abuse clinic

The individuals identified above may share your health information with each other for purposes of treatment, payment, and health care operations, as further described in the Notice.

B. THE FOLLOWING ARE USES AND DISCLOSURES OF HEALTH INFORMATION THAT YOU MAY EXPECT ON A ROUTINE BASIS FROM OUR OFFICE:

1. **Treatment.** We may use health information about you to provide you with treatment or services. Individuals and programs within ARA may share health information about you to coordinate the services you may need, such as clinical examinations, medications, hospitalizations or transfers or referrals for follow-up care.
2. **Payment.** We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us.
3. **Health Care Operations.** We may use or disclose your health information in order to perform the necessary administrative, educational, quality assurance, and business functions of our clinic, including but not limited to requiring you to sign in upon arrival, calling out your name when it is time for your visit, and discussing aspects of your medical care when consulting with others regarding your care, next visit or special needs.

C. USES AND DISCLOSURES OF HEALTH INFORMATION IN SPECIAL SITUATIONS.

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures as provided for in this Notice.

1. **Appointment Reminders.** We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment. Be aware that these reminders may be left on your answering machine at your home.

2. **Family Members and Friends.** We may disclose your health information to family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if your spouse comes into the therapist's office with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

D. OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OF HEALTH INFORMATION.

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your permission. These instances are as follows:

1. **As required by law.** We may disclose your health information when required by federal, state, or local law to do so.
2. **Public Health Activities.** We may disclose your health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury, or disability; to report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.
3. **Health Oversight Activities.** We may disclose your health information to a health oversight agency that is authorized by law to conduct health oversight activities, including audits, investigations, inspections, or licensure and certification surveys. These activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and to ensure compliance with applicable state and federal laws and regulations.
4. **Judicial or administrative proceedings.** We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose your health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but only if efforts have been made to (i) notify you of the request for disclosure or (ii) obtain an order protecting your health information.
5. **Worker's Compensation.** We may disclose your health information to worker's compensation programs when your health condition arises out of a work-related illness or injury.
6. **Law Enforcement Official.** We may disclose your health information in response to a request received from a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.
7. **Coroners, Medical Examiners, or Funeral Directors.** We may disclose your health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We also may disclose your health information to a funeral director for the purpose of carrying out his/her necessary activities. We may provide this information when death is anticipated, not just after.
8. **Research.** We may use or disclose your health information for research purposes under certain limited circumstances. In most instances, we will ask for your specific permission to use or disclose your health information if the researcher will have access to your name, address, or other identifying information.
9. **To Avert a Serious Threat to Health or Safety.** We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.
10. **Military and Veterans.** If you are, or were a member of the armed forces, we may use or disclose your health information as required by military command authorities or the Veteran's Administration.
11. **National Security and Intelligence Activities.** We may use or disclose your health information to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.
12. **Disaster Management.** In the event of a disaster, your health information may be released as necessary to allow for your treatment, continued management, transferring of prescriptions or similar activities.

E. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. You have the right to revoke a written authorization at any time as long as you do so in writing. If you revoke your authorization, we will no longer use or disclose your health information for the purposes identified in the authorization, except to the extent that we have already taken some action in reliance upon your authorization. Note: Revoking consent to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with that organization. Such a violation may result in legal consequences for you.)

F. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have the following rights regarding your health information. You may exercise each of these rights, in writing, by providing us with a completed form that you can obtain from our front desk. In some instances, we may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding how to exercise your rights, and the associated costs, can be obtained from our practice receptionists.

1. **Right to Inspect and Copy.** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records. It does not include information that is needed for civil, criminal or administrative actions or proceedings. As permitted by Federal regulations, we require that requests to inspect or copy protected information be submitted in writing. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

   As permitted by Federal regulations, we require that requests to inspect or copy protected information be submitted by completing a form that is available at the reception desk. To inspect or obtain a copy of the health information that may be used to make decisions about you, you must submit this form to the program director of the facility where you are receiving services. We may deny your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. A Medical Records Access Review Committee will review your request and denial. The person(s) conducting the review will not include the person who denied your request. We will notify you of the outcome of the review and comply with the outcome.
2. **Right to Correct.** You have the right to request corrections be made to your health information maintained by our office.
3. **Right to Amend.** You have the right to request an amendment of your health information that is maintained by our office and is used to make health care decisions about you. We may deny your request if it is not properly submitted or does not include a reason to support your request. We may also deny your request if the information sought to be amended: (a) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the information that is kept by or for our office; (c) is not part of the information which you are permitted to inspect and copy; or (d) is determined to be accurate and complete.

   To request an amendment, your must complete the appropriate form and submit it to the Director of the program in which you are enrolled. In addition, you must provide a reason that supports your request.
4. **Right to an Accounting of Disclosures.** You have the right to request an accounting of the non-routine disclosures of your health information made by us. This accounting will not include disclosures of health information that we made for (1) purposes of treatment, payment or health care operations; (2) made for national security; (3) made to correctional and other law enforcement custodial situations; (4) made based on your written authorization; (5) made to person involved in your care; or, (6) made prior to April 14, 2003.

   To request this list, or an accounting of disclosures, you must submit your request in writing to the Director of the program in which you are enrolled for treatment. Your request must state a time period which may not be longer than 6 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 or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw of modify your request at that time before any costs are incurred.
5. **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, such as a family member or friend, who is involved in your care or in the payment of your care. For example, you could ask that we not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request. If we do agree, that agreement must be in writing and signed by you and us.

   To request restrictions, you must make your request in writing to the Director of the program in which you are enrolled for treatment. Your request should detail (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)
6. **Right to Request Confidential Communications**. You have the right to request that we communicate with you about your health care 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 your assigned therapist. Your request should describe how and/or where you wish to be contacted. We will not ask you the reason for this request and we will make every reasonable accommodation to honor your request.
7. **Right to a Paper Copy of this Notice.** You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. ARA reserves the right to modify the privacy practices outlined in this notice at any time.

G. QUESTIONS OR COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with our Administrative offices or any of the following governmental agencies. To file a complaint you can do so by sending a letter outlining your concerns to:

To file a complaint with the ARA Administrative offices, contact:

Corporate Compliance Officer
ARA
4222 Bolivar Road
Wellsville, NY 14895

Or,

Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C 20201

Or,

Office for Civil Rights
US Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3313
New York, NY 10278

Voice Phone: (212) 264-3313
FAX: (212) 264-3039
TDD: (212) 264-2355
OCR Hotlines – (Voice Phone) 1-800-368-1019

You will not be penalized for filing a complaint.

Effective date of this privacy notice is 4/14/2003.

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Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for ARA.

Name of Client (Print or Type)

_____ _____
Signature of Client Date

_____ _____
Signature of Client Representative Date
(Required if the client is a minor or an adult who is unable to sign this form.)

_____
Relationship of Client Representative to Client

Attempt to Obtain Acknowledgment

An attempt was made to obtain an acknowledgment of receipt of the Notice of Privacy Practices on _____.
The acknowledgment was not obtained because: (Date)

[ ] The client was undergoing emergency treatment [ ] The client declined to sign the acknowledgement
[ ] Other _____

_____
Name of Client (Print or Type)

_____
Name of Staff Member

_____
Date

Information Release Authorization

May we leave a message about your care or appointment(s) on your answering machine or voice mail OR on the answering machine or voice mail of your approved contacts?

☐ Yes ☐ No _____ (Initials)

Please indicate who may be given information about your care or condition:

☐ Spouse ☐ Specific Children: Please Specify:_____
☐ All Children ☐ Other Family: Please Specify:_____
☐ Other: Please Specify:_____