

# *Connections of Central New York, Inc.*

4675 Brickyard Falls Road

Manlius, NY 13104

(315) 692-2000

## **NOTICE OF PRIVACY PRACTICES**

Effective Date: February 1, 2010

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT PEOPLE WE SUPPORT MAY BE USED AND DISCLOSED, AND HOW PEOPLE WE SUPPORT, THEIR GUARDIANS AND/OR THEIR PERSONAL REPRESENTATIVES, CAN GET ACCESS TO THIS INFORMATION. *GUARDIANS AND PERSONAL REPRESENTATIVES SHOULD BE AWARE THAT THE WORD "YOU" IN THIS NOTICE REFERS TO THE PEOPLE WE SUPPORT, NOT TO THE GUARDIAN.* 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 our agency, its staff, and affiliated health care providers that jointly provide treatment, and perform payment activities and business operations, with our agency. A copy of our current notice will always be posted in our reception area. You will also be able to obtain a copy by accessing our website at [www.connectionsny.org](http://www.connectionsny.org), calling our office at (315) 434-9597, or asking for one at the time of your next visit.

*If you have any questions about this notice or would like further information, please contact the Privacy Officer of **Connections of Central New York, Inc.**, 4675 Brickyard Falls Road Manlius,, New York 13104 at (315) 692-2000.*

### **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 agency. You may also initiate the transfer of your records to another person by completing an Authorization form. If you provide us with written Authorization, you may revoke that Authorization at any time, except to the extent that we have already relied upon it. To revoke an Authorization, please write to the Privacy Officer at *Connections of Central New York, Inc.*, 4675 Brickyard Falls Road Manlius,, New York 13104.

**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:

- We will request your general consent to use and disclose your health information to treat your condition, collect payment for that treatment, or run our agency's normal business operations. This includes when we are communicating with other **MR/DD** agencies which are currently providing services to you, or working with us to plan for services for you, if this communication is about treatment, payment, or agency operations.
- **Exception For Facility Directory And Disclosure To Friends And Family 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. For more information, see pages 6 of this Notice.

- **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. For more examples, see pages 6 through 9 of this Notice.
- **Exception If Information Does Not Identify You.** We may use or disclose your health information if we have removed any information that might reveal who you are.

**How To Access Your Health Information.** You generally have the right to inspect and copy your health information. For more information, please see page 9 of this Notice.

**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. For more information, please see page 10 of this Notice.

**How To Keep Track Of The Ways Your Health Information Has Been Shared With Others.** You have the right to receive a list from us, called an “**Accounting List**,” which provides information about when and how we have disclosed your health information to outside persons or organizations. Many routine disclosures we make will not be included on this accounting list, but the accounting list will identify non-routine disclosures of your information. For more information, please see page 10 of this Notice.

**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. For more information, please see page 11 of this Notice.

**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, such as at work instead of at home. We will try to accommodate all reasonable requests. For more information, please see page 12 of this Notice.

**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 Hygiene 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 the Privacy Officer *at Connections of Central New York, Inc.* 518 4675 Brickyard Falls Road Manlius,, New York 13104, at (315) 692-2000.

**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 the Privacy Officer of *Connections of Central New York, Inc.* at (315) 692-

2000. You may also obtain a copy of this Notice from our website at [www.connectionsny.org](http://www.connectionsny.org), or by requesting a copy at your next visit.

**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, and we will be required by law to abide by its terms. We will post any revised Notice in our agency reception area. You will also be able to obtain your own copy of the revised notice by accessing our website at [www.connectionsny.org](http://www.connectionsny.org), calling our office at (315) 692-2000, or asking for one at the time of your next visit. The effective date of the Notice will always be noted in the top right corner of the first page.

**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. To file a complaint with us, please contact the Privacy Officer at *Connections of Central New York, Inc.*, 4675 Brickyard Falls Road Manlius,, New York 13104, at (315) 692-2000. **No one will retaliate or take action against you for filing a complaint.**

### CONFIDENTIALITY OF PSYCHOTHERAPY NOTES

Psychotherapy notes are notes that our mental health counseling staff might make about your private counseling sessions, or your group, joint, or family counseling sessions, that are maintained separate from the rest of your clinical records. These notes can only be used and disclosed as described below.

***With your general written consent***, psychotherapy notes about you may be used and disclosed in the following situations:

- The mental hygiene professional who created the notes may use them to provide you with further treatment;
- The mental hygiene professional who created the notes may disclose them to students, trainees, or practitioners in mental hygiene who are learning under supervision to practice or improve their skills in group, joint, family, or individual counseling;
- The mental hygiene professional who created the notes may disclose them as necessary to defend his or herself, or the agency, in a legal proceeding initiated by you or your personal representative;

***Without your general written consent***, psychotherapy notes may be used and disclosed only in the following situations:

- The mental hygiene professional who created the notes may disclose them as required by law;
- The mental hygiene professional who created the notes may disclose the notes to appropriate government authorities when necessary to avert a serious and imminent threat to the health or safety of you or another person;
- The mental hygiene professional who created the notes may disclose them to the United States Department of Health and Human Services when that agency requests them in order to investigate the mental hygiene professional's compliance, or the agency's compliance, with Federal privacy and confidentiality laws and regulations; and
- The mental hygiene professional who created the notes may disclose them to medical examiners and coroners if necessary to determine your cause of death.

***Your special written authorization*** is required for all other uses and disclosures of psychotherapy notes.

## WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- the fact that you are a participant at, or receiving treatment or health-related services from, our agency;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future (such as a medication or treatment); or
- information about your health care benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

- geographic information (such as where you live or work);
- demographic information (such as your race, gender, ethnicity or marital status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); and
- other types of information that may identify who you are.

## HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

### **1. Treatment, Payment And Agency Business Operations**

*With your consent, our agency and staff may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run the agency's normal business operations. Your health information may also be shared with affiliated agencies so that they may jointly perform certain payment activities and business operations along with our agency. Your health information also may be disclosed to another health care provider for its treatment and payment activities, and for certain limited business operations by it. Below are further examples of how your information may be used and disclosed by our agency.*

**Treatment (45 C.F.R. §§164.506(1) & (2)).** We may share your health information with doctors, nurses, therapists, aides and other health care professionals at our agency who are involved in providing services to you, and they may in turn use that information to diagnose or treat you, or to develop a plan of services for, you. A health care professional at our agency may share your health information with another health care professional inside our agency. With your consent, we may share your health information with a health care professional at another agency to determine how to diagnose or treat you, or with another agency or provider to whom you have been referred for further health care. Finally, with your consent we may share your health information with others outside the agency as necessary to carry out your treatment plan; for example, we may disclose certain information about your health to a prospective employer in connection with a job placement or training program.

**Payment** With your consent, we may use your health information or share it with others so that we obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have provided services to you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your services. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your services, such as care provided at a residential treatment facility. Finally, we may share your health information with other providers and payors for their payment activities.

**Business Operations** We may use your health information or share it with others in order to conduct our normal business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you. With your consent, we may also share your health information with another company that performs business services for us, such as billing companies. If so, we will have a written contract to ensure that this company also protects the privacy of your health information. Finally, we may share your health information with other providers and payors for certain of their business operations if that other party also has or had a treatment or payment relationship with you, and in that event we will only share information that pertains to that relationship.

**Appointment Reminders, Treatment Alternatives, Benefits And Services** We may use your health information when we contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

**Fundraising** (We may use demographic information about you, including information about your age and gender, and where you live or work, and the dates that you received treatment, in order to contact you to raise money to help us operate. We may also share this information with a charitable foundation that will contact you to raise money on our behalf. If you do not want to be contacted for these fundraising efforts, please write to the Privacy Officer at *Connections of Central New York, Inc.* at (315) 692-2000.

## **2. Facility Directory / Friends And Family**

*We may use your health information in, and disclose it from, our Facility Directory, or share it with friends and family involved in your care, without your written Authorization or other written permission. We will always give you an opportunity to object unless there is insufficient time because of a medical emergency (in which case we will discuss your preferences with you as soon as the emergency is over). We will follow your wishes unless we are required by law to do otherwise.*

**Agency Directory** Unless you object, we will include your name, your location in our facility, your general condition (e.g., fair, stable, critical, etc.) and your religious affiliation in our Agency Directory while you are a person we support at our facility. This directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if he or she does not ask for you by name.

**Friends And Family Involved In Your Care.** If you do not object, we may share your health information with a family member, relative or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative, or another person responsible for your care about your location and general condition here at our facility, or about the unfortunate event of

your death. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

**Incidental Disclosures.** While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other people we support in the treatment area may see, or overhear discussion of, your health information.

### **3. Public Need**

*We may use your health information, and share it with others, in order to meet important public needs. We will not be required to obtain your written authorization, consent or any other type of permission before using or disclosing your information for these reasons.*

**As Required By Law.** We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

**Public Health Activities.** We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

**Victims Of Abuse, Neglect Or Domestic Violence.** We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

**Health Oversight Activities.** We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

**Product Monitoring, Repair And Recall.** We may disclose your health information to a person or company that is required by the Food and Drug Administration to: (1) report or track product defects or problems; (2) repair, replace, or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.

**Lawsuits And Disputes.** We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

**Law Enforcement.** We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your consent because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

**To Avert A Serious Threat To Health Or Safety.** We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

**National Security And Intelligence Activities Or Protective Services.** We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

**Military And Veterans.** If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

**Inmates And Correctional Institutions.** If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

**Workers' Compensation.** We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

**Coroners, Medical Examiners And Funeral Directors** In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties

**Organ And Tissue Donation.** In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

**Research.** In most cases, we will ask for your written Authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use

and disclose your health information without your Authorization if we obtain approval through a special process to ensure that research without your Authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your Authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

## **YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION**

*We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.*

### **1. Right To Inspect And Copy Records**

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the Privacy Officer at *Connections of Central New York, Inc., 4675 Brickyard Falls Road Manlius,, New York 13104*. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is \$0.75 per page and must generally be paid before or at the time we give the copies to you.

We will respond to your request for inspection of records within **10** days. We ordinarily will respond to requests for copies within **30** days if the information is located in our facility, and within **60** days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written Notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The Notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

### **2. Right To Request Amendment of Records**

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to the Privacy Officer at *Connections of Central New York, Inc., 4675 Brickyard Falls Road Manlius,, New York 13104*. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within **60** days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

### **3. Right To An Accounting Of Disclosures**

After April 14, 2003, you have a right to request an “accounting of disclosures” which is a list that contains certain information about how we have shared your information with others. An accounting list, however, will not include any information about:

- Disclosures we made to you;
- Disclosures we made pursuant to your authorization;
- Disclosures we made for treatment, payment or health care operations;
- Disclosures made in the facility directory;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures that were incidental to permissible uses and disclosures of your health information;
- Disclosures for purposes of research, public health or our normal business operations of limited portions of your health information that do not directly identify you;
- Disclosures about inmates to correctional institutions or law enforcement officers; or
- Disclosures made before April 14, 2003.

To request this accounting list, please write to the Privacy Officer at *Connections of Central New York, Inc., 4675 Brickyard Falls Road Manlius,, New York 13104*. Your request must state a time period within the past six years (but after April 14, 2003) for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. You have a right to receive one accounting list within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting list in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting list within 60 days. If we need additional time to prepare the accounting list you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting list. In rare cases, we may have to delay providing you with the accounting list without notifying you because a law enforcement official or government agency has asked us to do so.

### **4. Right To Request Additional Privacy Protections**

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our agency’s normal business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information

