ADOLESCENT & FAMILY COUNSELING CENTER, LLC
The Republic Building 350 South Main Street Cheshire, CT 06410-3160
Cheshire Danbury
203 271-1234 203 790-1234
http://www.AFCCenter.Org/ Fax: 203 272-9094
Director: Herbert Jay Rosenfield, ACSW, LCSW, BCD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Your health records contain personal information about you and your health. This information about you -- that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services -- is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may disclose your PHI in accordance with applicable HIPAA ("Health Insurance Portability and Accountability Act") law and it is consistent with the laws of the State of Connecticut, the NASW Code of Ethics, and that of other professional mental health practitioners, including Psychiatrists, Psychologists, Marriage & Family Therapists, Licensed Professional Counselors, and Counselors. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. We may mail you information about our groups, courses, workshops, programs, & presentations that may be of assistance to you and your family.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect, the abuse of the elderly or of handicapped individuals, or mandatory government agency audits or investigations (such as the social work licensing board or the health department);
- Required by Court Order, warrant, or subpoena;
- Necessary in emergency situations to protect your health or safety; or
- Necessary to prevent or lessen a serious and imminent threat to your health or safety, health or safety of a person, or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: With your verbal permission, we may use or disclose your information to family members that are directly involved in your treatment.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked by you at any time, in writing.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. If you have any questions, you may speak with your clinician, or to ask questions or to exercise any of these rights, please submit your request in writing to our Privacy Officer, Linda J. Rosenfield, LCSW, at the Adolescent & Family Counseling Center's Cheshire office.

* **Right of Access to Inspect and Copy.** With the exception of the psychotherapy notes, you have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
* **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
* **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
* **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
* **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
* **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Linda J. Rosenfield, LCSW, at the Adolescent & Family Counseling Center's Cheshire office, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you in any way for filing a complaint.**

The effective date of this Notice is April 14, 2003; reviewed and approved 07/01/2019

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Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name: _____
DOB: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Adolescent & Family Counseling Center's "Notice of Privacy Practices". I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Linda J. Rosenfield, LCSW, at the Adolescent & Family Counseling Center's Cheshire Office, 203 271-1234.

_____ ___/___/_____
Signature of Patient/Client Date

_____ ___/___/_____
Signature of: __Parent __Guardian or __Personal Representative * Date

* If you are signing as a Personal Representative of an individual, please describe your legal authority to act for this individual (Power of Attorney, Healthcare Surrogate, etc.):

_____

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❑ Patient/Client Refuses to Acknowledge Receipt:

_____ ___/___/_____
Signature of Staff Member Date