

NOTICE OF PRIVACY PRACTICES

This document summarizes your rights under the HIPAA privacy regulation. A full description is available to you upon your request. This notice also describes how information about our consumers may be used and disclosed, and how our consumers, 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 consumer, not to the guardian.* Please review this document carefully.

We are committed to protecting the privacy of you and your family, and sharing information about you only with those who need to know and who are permitted by law to receive this information. We are required by both federal and state law to protect the privacy and confidentiality of mental health information that may reveal your identity, and to provide you with a copy of this notice which describes the clinical information privacy practices of our agency, its staff, and affiliated health care providers that jointly provide service and treatment and perform payment activities and business operations, with our agency. A copy of our current notice will be posted in our reception areas. You will also be able to obtain a copy by accessing our website at www.liberty-resources.org, calling our office at 315-425-1004, 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 Director of the Division from which you receive services at 315-425-1004.

CONFIDENTIALITY OF MENTAL HEALTH INFORMATION

Clinical information about you may be used by our agency (or its business associates) in connection with our duties to provide you with treatment, to obtain payment for that treatment, or to conduct our agency's business operations.

1. We will not disclose clinical information about you **without your consent** or written authorization, except for the following purposes:
 - When we are communicating with other agencies that 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.
 - "treatment" means that we may share clinical information about you to plan for and provide services for you. Though HIPAA does not require us to do so, we will obtain an authorization to share information about you with others outside our agency when necessary to provide services and to plan for services for you.
 - "payment" means that we may use clinical information about you, or share it with others in and outside our agency so that we obtain payment for your services.
 - "operations" means that we may use clinical information about you, or share it with others, in order to conduct our normal business

operations. For example, we may use clinical information about you to evaluate the performance of our staff in providing services to you, or to educate our staff on how to improve the care they provide for you.

- To a personal representative who is authorized to make health care decisions on your behalf;
 - Other entities to whom we can disclose your protected health information, without your authorization are listed in the document, “How You Can Exercise Your Rights to Access and Control of Your Clinical Information.”
2. **If you do not object**, we may disclose information about you to friends and family involved in your care. We will ask you whether you have any objection.

WHAT INFORMATION IS PROTECTED

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

- The fact that you are a participant at, or receiving services from, our agency;
- Information about your condition;
- 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 or ethnicity);
- Unique numbers that may identify you (such as your social security number, your phone number, or your Medicaid number); and
- Other types of information that may identify who you are.

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

YOUR RIGHTS

The following are described more fully in “How You Can Exercise Your Rights to Access and Control of Your Clinical Information.”

How To Access Your Clinical Information. You generally have the right to inspect and copy your clinical information.

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

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 clinical information about you 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.

How To Request Additional Privacy Protections. You have the right to request further restrictions on the way we use your clinical information about you 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, such as at home instead of at work. 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 clinical information. Parents and guardians will generally have the right to control the privacy of clinical 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 and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your clinical records include this type of information, you will be provided with separate notices explaining how the information will be protected.

How To Obtain A Copy Of This Notice. You have the right to a paper copy of this notice. To request a copy, just ask program staff. You may also obtain a copy of this notice from our website at www.liberty-resources.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 clinical 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.liberty-resources.org, calling our office at 315-425-1004 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 Deputy Executive Director at 315-425-1004. *No one will retaliate or take action against you for filing a complaint.*

The NYS Department of Health (under which we bill Medicaid) has interpreted NYS Law to **require a one-time only consent** for use and disclosure of your Protected Health Information for Treatment, Payment and Operations. The Agency is requesting each consumer's signature on the following General Consent for use and disclosure for payment and operations. The agency will obtain specific written authorizations for use and disclosure for treatment.

SIGNATURE

By signing below, I consent to the use and disclosure of my health information to seek and receive payment for services given to me, and for the business operations of Liberty Resources. I understand that for use and disclosure of my health information for treatment purposes, the Agency will obtain my specific written authorization.

By signing below, I acknowledge that I have been provided a copy of the Liberty Resources, Inc. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Liberty Resources, Inc. and how I may obtain access to this information. I have been informed that Liberty Resources staff will provide me with a fuller description of these rights upon my request.

Signature of Consumer or Personal Representative

Print Name of Consumer or Personal Representative

Date

Description of Personal Representative's Authority

Signature of Witness (if necessary)