Rev 4/23/14

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
CAPITOL REGION MENTAL HEALTH CENTER (CRMHC)
NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE: September 23, 2013

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.

I. PURPOSE OF THE NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices (the "Notice") is meant to inform you of the ways we may use or disclose your protected health information. It also describes your rights to access and control your protected health information and certain obligations we have regarding use and disclosure of your protected health information.

CRMHC is required by law to maintain the privacy of your protected health information and wants you to know about our practices for protecting your health information.

CRMHC is required by law to provide you with this Notice of our legal duties and privacy practices with respect to your protected health information and to abide by the terms of the Notice that is currently in effect. The medical information we maintain may come from any of the providers from whom you have received services. The information about you created and received by us, including demographic information, that may reasonably identify you and that relates to your past, present or future physical or mental health or condition or payment for the provision of your health care is known as Protected Health Information, or PHI. We will not use or disclose your PHI without your permission, except as described in this notice.

We may revise our Notice at any time. The new revised Notice will apply to all of your protected health information maintained by us. You will not automatically receive a revised Notice. If you would like to receive a copy of any revised Notice, you should access our web site at www.ct.gov/DMHAS, contact **CRMHC**, or ask for a copy at your next appointment.

II. HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

FACILITY NAME will ask you to sign a consent form that allows **CRMHC** to use and disclose your protected health information for treatment, payment and health care operations. You will also be asked to acknowledge receipt of the Notice.

The following categories describe some of the different ways that we may use or disclose your protected health information. Even if not specifically listed below, **CRMHC** may use and disclose your protected health information as permitted or as required by law or as authorized by you. We will make reasonable efforts to limit access to your protected health information to those persons or classes of persons, as appropriate, in our workforce who needs access to carry out their duties.

FOR TREATMENT – We may use and disclose your protected health information to provide you with medical treatment and related services. For example, your protected health information may be used to refer you to other providers or to send your records to another treating health care professional.

FOR PAYMENT - We may use and disclose your protected health information so that we can bill and receive payment for the treatment and related services you receive. For example, we may disclose you protected health information to the state Department of Administrative Services to bill for your healthcare services.

FOR HEALTH CARE OPERATIONS - We may use and disclose your protected health information as necessary for the operations of **CRMHC**, such as quality assurance and improvement activities. For example, we may disclose your information to internal staff for evaluation of the quality of services provided.

BUSINESS ASSOCIATES – We may disclose your protected health information to a Business Associate that provides services, such as billing or legal, to **CRMHC**. In order to protect your information, we require Business Associates to enter into a written contract that requires them to safeguard your information.

APPOINTMENT REMINDERS – We may use and disclose protected health information to contact you as a reminder that you have an appointment with **CRMHC**.

PUBLIC HEALTH ACTIVITIES – We may disclose your protected health information to a public health authority that is authorized by law to collect or receive such information, such as mandated reporting of disease, injury or vital statistics.

HEALTH OVERSIGHT ACTIVITIES – We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections.

JUDICIAL PROCEEDINGS – If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a court order if permitted by law.

LAW ENFORCEMENT – We may disclose your protected health information for certain law enforcement purposes if permitted or required by law.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, ORGAN PROCUREMENT ORGANIZATIONS – If you are deceased, we may disclose limited information to a coroner, medical examiner, funeral director, or if you are an organ donor, to an organization involved in the donation of organs and tissues.

TO AVERT SERIOUS THREAT – We may use or disclose your protected health information when necessary to prevent a serious threat to the health or safety of you or others. Any disclosure would be to someone able to help prevent the threat.

NATIONAL SECURITY MATTERS – We may use and disclose your health information without you authorization to authorized Federal officials for the purpose of conducting national security and intelligence activities. These activities may include protective services for the President and others.

MILITARY ACTIVITIES – We may use or disclose your health information without your authorization if you are a member of the Armed Forces, for the activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, when applicable legal requirements are met.

RESEARCH – Under certain circumstances, we may disclose protected health information for research purposes.

SPECIAL RULES REGARDING MENTAL HEALTH RECORDS, SUBSTANCE ABUSE TREATMENT INFORMATION AND HIV-RELATED INFORMATION – For disclosures concerning protected health information relating to care for psychiatric conditions, substance abuse or HIV-related testing and treatment, special restrictions generally apply. For example, we generally may not disclose this specially protected information in response to a subpoena, warrant or other legal process unless you sign an Authorization or, in certain circumstances, if the court orders disclosure.

MENTAL HEALTH INFORMATION – Certain mental health treatment information may be disclosed for treatment and payment purposes as permitted or as required by law. Otherwise, we will only disclose such information pursuant to an authorization, court order or as otherwise required by law. For example, all communications between you and a psychologist, psychiatrist, social worker and certain therapists and counselors will be privileges and confidential in accordance with State and Federal law.

- For patients admitted with a legal status of 54-56d, written reports will be disclosed as required by or from the Superior Court as to whether you are competent to stand trial. The report to the court will include clinical findings, facts on which the findings are based

and the opinion to whether you have attained competency and/or progress towards competency.
- For patients admitted with a legal status of 17a-582, written reports will be disclosed to the PSRB at least every six months.

SUBSTANCE ABUSE TREATMENT INFORMATION – If you are receiving treatment or diagnosis for substance abuse, the confidentiality of alcohol and drug abuse patient records is protected by Federal law and regulations.

- Participation in the substance abuse program requires **CRMHC** to obtain your written consent before it can disclose information about you for payment. Generally, you must also sign a written authorization before **CRMHC** can share information for treatment purposes or for healthcare operations.
- Generally, **CRMHC** may not disclose to a person outside of the program that you attend the program or have received any sort of services from the facility, or disclose any information identifying you as an individual being treated for drug or alcohol abuse, unless:
  - You consent in writing; or
  - The disclosure is allowed by a court order; or
  - The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation;
  - In order to report a crime committed by a patient either at the facility or against an employee of the facility
  - In order to report suspected child abuse or neglect as required by law

HIV-RELATED INFORMATION – We may disclose HIV-related information as permitted or required by State law. For example, your HIV-related information, if any, may be disclosed without your authorization for treatment purposes, certain health oversight activities, pursuant to a court order, or in the event of certain exposures to HIV by personnel of **CRMHC**, another person or a known partner (if certain conditions are met).

III. WHAT ARE YOUR RIGHTS? YOU HAVE THE RIGHT TO:

- Request, in writing, restrictions on certain uses and disclosures of your Protected Health Information (PHI).
- Receive reasonable confidential communication of PHI, e.g. contact you at a place of your choosing.
- Inspect and copy your medical record by written request, with some exceptions. You have the right to obtain an electronic copy of any of your protected health information that we maintain in electronic format. You have the right to request that **CRMHC** transmit a copy of your protected health information directly to another person or entity designated by you. **CRMHC** reserves the right to deny the request, to which you may make a further appeal.
- Request an amendment of your medical record for as long as the information is maintained by or for **CRMHC. CRMHC** reserves the right to deny the request, to which you may make a further appeal.
- Receive an accounting of **CRMHC** disclosures of your PHI during the six years prior to your request.
- Receive a paper copy of this Notice.
- Request transmission of your protected health information in electronic format.
- Receive notification following a breach of your unsecured PHI.
- Restrict the disclosure of PHI to health plans for the purposes of payment if you paid out-of-pocket in full for the health services or item to which the information relates.
- File a Complaint with us or with the Secretary of Health and Human Services.

IV. USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

The following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures of psychotherapy notes
- Uses and disclosures of PHI for marketing purposes
- Disclosures that constitute a sale of your PHI
- You have the right to opt out of being contacted or receiving notices for fundraising
- Other uses and disclosures not described in the Notice of Privacy Practices

You may revoke an authorization at any time, except to the extent that we have already acted on it.

V. HOW YOU CAN REPORT A PROBLEM

If you feel your privacy rights have been violated, you may file a complaint with the **CRMHC** Privacy Officer at ***(860) 297-0830,*** the State of Connecticut, Department of Mental Health and Addiction Services (DMHAS), Privacy Officer at (860) 418-6901, or the Secretary of the United States Department of Health and Human Services (DHHS), Office for Civil Rights (OCR) at: U.S. DHHS, OCR, J.F. Kennedy Federal Building – Room 1875, Boston, Massachusetts 02203. Voice phone: (617) 565-1340. TDD: (617) 565-1343. FAX: (617) 565-3809.

There will be no retaliation for filing a complaint.

WOULD YOU LIKE MORE INFORMATION?

If you have questions and would like more information, you may contact the **CRMHC** Privacy Officer at ***(860) 297-0830***, or the DMHAS Privacy Officer at (860) 418-6901.

I hereby acknowledge receipt of the CRMHC Notice of Privacy Practices:

_____ _____

Client Signature Date

_____ _____

Client Name (please print) Witness Signature and Date

If client refuses to sign Notice of Privacy Practices, please explain:_____