NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

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

Effective: April 14, 2003
Revised: May 3, 2011
Revised: September 23, 2013

We respect client confidentiality and only release confidential information about you ion accordance with the Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by this agency. We are obligated under law to protect the privacy of your information, and we are required to honor the terms of this notice.

Privacy Contact: If you have any questions bout this policy or your rights, contact Kim Caraker, Medical Records/File Clerk, 204 South Street, PO Box 548, Anna, IL 62906. Phone: 618-833-8551.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your confidential information with others both within and outside our agency. This includes releasing information for the purpose of:

Treatment. We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our agency that we are consulting with or referring you to. We may disclose your confidential information without your consent to the Illinois Department of Human Services for the purpose of admission, treatment, planning and discharge to and from State operated facilities. In order to release your information to any other person or agency for the purpose of admission, treatment, planning and discharge we must obtain your written permission.

Payment. With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting appropriate companies or organizations for prior approval of planned treatment or for billing purposes. **You have a right to restrict certain disclosures of your protected health information if you pay out of pocket in full for the services provided to you.**

Healthcare Operations. We may use information about you, **with or without your written consent**, to coordinate our business activities. This may include setting up your appointments, reviewing your care, verifying your payment information, and training staff.

Information Disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will leave appointment information on your answering machine or **voice mail, or leave an email or text message** unless you tell us not to.

As Required By Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners. We are required to disclose information about the circumstances of a client's death to a coroner who is investigating.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. We are also required to share information, if requested, with the Department of Health and Human Services to determine our compliance with federal laws related to health care and to Illinois State Agencies that fund our services **or for coordination of your care.**

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to a person or the public.

Fundraising. As a not for profit provider of health care services we need assistance in raising money to carry out our mission. We may contact you to seek a donation. **You will have the opportunity to opt out of receiving such communication. You may also opt out of our providing your contact information for any marketing that results in compensation to the Agency.**

Except for these instances when we can release information without your consent, we will not release confidential information about you without your written permission.

CLIENT RIGHTS REGARDING CONFIDENTIAL INFORMATION

Copy of Record. You are entitled to inspect the client record our agency has generated about you. **We may charge you a reasonable fee for copying and mailing your record. Current allowable fees are determined by the Office of the Comptroller of Illinois and can be found at http://www.ioc.state.il.us/office/fees.cfm. For assistance with obtaining a copy of your record,** contact the Privacy Contact shown above.

Release of Records. You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization. **Except as described in this Notice or as required by Illinois or Federal law, we cannot release your protected health information without your written consent.**

Restriction of Record. You may ask us not to use or disclose part of the clinical information. This request must be in writing. The **Agency** is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the **Privacy Contact**.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. **We also will be glad to provide you information by**

email if you request it. If you wish us to communicate by email you are also entitled to a paper copy of this privacy notice.

Amending Records. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this, contact the Privacy Contact. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to your **Privacy Contact**. We will notify you of the cost involved in preparing this list.

Notification of Breach: You have a right to be notified if there is a breach of your unsecured protected health information. This would include information that could lead to identity theft. You will be notified if there is a breach or a violation of the HIPAA Privacy Rule and there is an assessment that your protected information may be compromised.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our **Privacy Contact** in writing at our office for further information. You also may complain to the Secretary of US Department of Health and Human Services if you believe our agency has violated your privacy rights. We will never retaliate against you in any way for filing a complaint.

Changes in Policy. The agency reserves the right to change its Privacy Policy base on the needs of the agency and changes in state and federal law.

CLIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Union County Counseling Services, Inc. and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. I understand that treatment for a mental illness can assist in my recover of function but treatment will not provide a cure. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducing the healthcare operations of the Agency. I authorize the Agency to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Agency may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (____)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/ COLLECTION FEE. I authorize payment to be made directly to the Agency for insurance benefits payable to me. I understand that I am financially responsible to the Agency for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorneys fees. (____)

PRIVACY POLICY. I acknowledge having received the Agency's, "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Agency has already made disclosures with my prior consent. (_____)

PROGRAM RULES. I acknowledge that I have received a copy of the program rules for Outpatient services at UCCS. (____)

______________________________	____________________	__________
Client or Authorized Person Signature	Relationship	Date

____
Print Name

______________________________	______________________________
Name of Minor (if applicable)	Witness Signature

☐ I have explained client rights and **Program Rules** and believe that s/he understood them.

______________________________	____________
Staff Signature	Date

☐ Patient unable to sign. Verbal consent given. Reason______________________________

Revised **11/19/2010;** 9/16/08

RIGHTS OF CLIENTS

A client has a right to adequate notice of the uses and disclosures of Protected Heath Information (PHI) that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to PHI.

The Notice of Privacy Practices summarizes all the rights of the client related to his identifiable health information.

The Client has the Following Rights:

1. Right to Request Restrictions of Uses and Disclosures of PHI. An entity must permit a patient to request that the covered entity restrict:
   (A) Uses or disclosures of PHI to carry out TPO; and
   (B) Listing client in its directory of individuals in the facility. (The client has a right to object to this information being shared with clergy.)
   (C) Sharing information with client's family member, relative or close personal friend.

The covered entity is not required to agree to the above restriction, but if it does, it may not use PHI in violation of such restriction except for emergency treatment.

2. To Request to Receive Communications of PHI by Alternative Means or at Alternative Locations. This must be permitted if the client clearly states that the disclosure of all or part of that information could endanger the individual. The covered entity can condition the provision of a reasonable accommodation on assurances of how payment will be handled.
3. Right to Copy of Record. This right currently exists for all clients under various Illinois statues, including those seeing general health care providers, those receiving specialized care for mental health, substance abuse, or AIDS treatment. An individual's access may be denied if the PHI was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. (This denial is very problematic under Illinois law).
4. Denial of Access. Although there are various circumstances where HIPAA allows the provider to deny access, these provisions are preempted by Illinois law, which allows the client access to his record in almost all circumstances.
5. Timely Access. Under HIPAA, copies of records are to be provided within 30 days.
6. Right to Amend PHI. The client has a right to have the Provider amend PHI as long as it is maintained in the designated record set. The Provider can deny making the amendment based on:
   (a) The record was not created by the Provider; or
   (b) The information is not part of the designated record set; or
   (c) The information is accurate and complete.

The Provider is to act within 60 days. See Request for Amendment of Clinical Record Form. A Provider can deny an amendment. The client can disagree with the denial, and then submit a statement, and the Provider can submit a rebuttal statement. This can all become part of the record.

Generally, if the client is disputing something in the record and it is questionable, then the Provider should include in the record the client's comments and make that part of the record. If the Provider

accepts amending the record, then the Provider should also notify others identified by the client as having received the PHI and needing the amendment.

7. Accounting for Disclosures of PHI. The client has a right to receive an accounting of the disclosures made of his PHI for a period of six years prior to the date the accounting is requested. This does not include giving an accounting when the disclosures were for:
    (a) Used to carry out treatment, payment and health care operations. (TPO)
    (b) Released due to a patient's authorization.
    (c) To persons involved in the individual's care.
    (d) That occurred prior to the compliance date for the covered entity.
    (e) Disclosures that are part of a limited data set.
    (f) Disclosures that are merely incidental to another permissible use or disclosure.

The six years begins to run forward starting with the effective date of April 14, 2003 or the first date of treatment by the patient after April 14, 2003.

The accounting must include the date of the disclosure and whom it was released to and a brief description of the PHI that was disclosed.

UNION COUNTY COUNSELING SERVICES, INC
STATEMENT OF RIGHTS

This agency is committed to insure that you receive professional and humanistic services directed toward your needs in a manner that protects your dignity and feelings of self-worth. As a client of our Agency you have the following rights:

CIVIL RIGHTS

1. You have the right to be treated with dignity and respect and,

2. You retain all rights, benefits, and privileges guaranteed by law.

DISCRIMINATION

Services will be provided to you and/or your family members without discrimination. Race, color, creed, religion, national origin, sex, sexual orientation, HIV/AIDS status, age, marital status, disability, financial status or status as a disabled veteran or Vietnam era veteran will not affect our services to you.

1. You have a right to receive services for which you are qualified. If requested, we will attempt to schedule services in a manner that minimizes your costs due to travel and/or loss of work time. If you are unable to pay for services, you may request to meet with someone that can help you in accesses services through this or another provider. No physical barriers will preclude treatment.

2. Services will be provided with a minimum of wasting time. The agency's operational hours will be reasonable convenient to all clients requesting services.

CONFIDENTIALITY

1. All information concerning you is held confidential and released only through procedures consistent with the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110/1-17]**,** Health Information Portability and Accountability Act (HIPAA), and professional ethics. Your records can be subpoenaed by the Court without your permission.

2. You have a right to review and approve any information being requested by another provider giving service to you. You must sign a Consent for Release of Information for any such information to be sent.

3. You have a right to the confidentiality of information protected by the AIDS Confidentiality Act and AIDS Code. The following information is protected by the AIDS Confidentiality Act and AIDS Code:

    a) a request for an/or signed consent to HIV antibody testing;

    b) an individual's HIV antibody or AIDS status;

    c) the fact that an individual has been tested for HIV antibodies, and/or the result of an HIV antibody test; and/or

    d) participation is pre-test and/or post-test counseling.

4. Unless disclosure is authorized by statute and rule, no information protected by the AIDS Confidentiality Act and the AIDS Code shall be released by any member of the agency to other staff members and/or any other person unless you sign a consent for the release of the information.

    NOTE: You are not required to tell any staff member whether you have been tested for HIV antibodies, and/or the result of any such test.

5. The agency is required by law to report any suspected child abuse and/or neglect.

6. The agency is required by law to report any suspected elder abuse and/or neglect.

TREATMENT

1. You have the right to an individual plan for treatment and will be expected to participate in your treatment planning. You may refuse treatment or any specific treatment and will be informed of the consequences resulting from a refusal of treatment and treatment procedure.

2. You have the right to know the name and professional credentials of anyone working with you, and due to the fact that UCCS works cooperatively with several departments at Southern Illinois University Carbondale, you may at some point in your treatment work with a student intern.

   a. You may be asked if an intern can observe a session, and you have the right to refuse this request.
   b. You may be assigned to work with an intern under the supervision of a licensed agency professional and you have the right to request alternate staff assignment.
   c. If you are assigned to work with an intern, that intern will provide an informational page to you about his/her credentials, his/her supervisor's name and credentials, and his/her educational goals as an intern at UCCS.

3. You have the right to be:

   a) treated with dignity and respect
   b) free from psychological abuse including humiliation, threatening and exploiting action
   c) free from physical/verbal abuse
   d) free from sexual abuse/harassment
   e) free from fiduciary abuse

4. You may request to participate in any staff meetings regarding yourself. You may be asked to attend pertinent clinical staffings regarding your treatment.

5. You may review your clinical records upon your written request. A staff member will be assigned to be with you during your record review. If you request a copy of information in your record, you will be charged photocopying fees. Records from other providers will not be released.

6. You have the right to be assigned a case manager who will advocate for you and who will assist you in obtaining services throughout your treatment program.

7. You will be advised of the positive effects and possible complications of any drugs or medication prescribed by any physician involved in your treatment. If medications are prescribed, you have the right to refuse specific medications.

8. Treatment will be provided in the least restricted environment.

9. An adult of sound mind has a right to make a declaration of preferences or instructions regarding mental health treatment as provided in the Mental Health Treatment Preference Declaration Act [755 ILLCS 43/1-75]. A Mental Health Preference Declaration is legal form you can create to give instructions about your mental health treatment, if you can't make those decisions yourself in the future. You may also name someone as your attorney-in-fact. That person can make your mental health decisions for you, or make sure the treatment instructions you put into your Declaration are followed. If you are interested in more information about creating a Mental Health Preference Declaration, a UCCS staff member can provide you with a guide booklet. If you decide you want a Declaration, you should talk about these decisions with a doctor and with a lawyer.

GRIEVANCE

1. If you feel your treatment has not been fair or reasonable, you may present your concerns in writing to the case manager assigned to you or to another employee of the agency. You are not required to use any specific

form to document your grievance; however, if you request a form one will be provided to you. The case manager will meet with you within 10 working days for your written grievance to attempt to resolve the concerns expressed in your written grievance. If you are not satisfied with the outcome of the grievance hearing with your case manager, you may present your concerns in writing to the program coordinator. The program coordinator will meet with you within 10 working days to attempt to resolve the concerns expressed in your written grievance. If you are not satisfied with the outcome of the grievance hearing with the program coordinator, you may present your concerns in writing to the Executive Director of Union County Counseling Service, Inc. The Executive Director will meet with you within 30 days of receipt of your written grievance to try to resolve your concerns. The Executive Director's decision on the grievance shall constitute a final administrative decision, except when such decision is subject to review by the provider's governing body, in which case the governing board's decision is final. All alleged Human Rights Violations will be taken to the Board of Directors. You have the right to have your complaints acted upon.

2. A record of grievance or adverse decision appeal and the response thereto shall be maintained by the provider.

3. You have the right to legal recourse, if you believe you have been treated improperly; you have the right to confer with a family attorney, physician, clergyman, and others at any time.

ETHICS

UCCS has an Ethics Handbook for the purpose of identifying and educating persons to ethical or human rights issues in mental health care. The handbook provides a foundation of knowledge for understanding and respecting clients' rights as well as the ethical handling of a variety of possible situations, with the goals of improving quality of care, insuring clients' fullest participation in their care, and protection of clients rights. Clients may request of copy of the Agency's "Ethics Handbook" at any time. Concerns that a violation may have accord may be brought to the attention of the treatment provider or any staff of the agency. All alleged violations will be fully investigated in accordance with policy.

EVALUATION

1. Consistent with providing professional and quality services, you will be given an opportunity to evaluate all aspects of your services and the personnel with whom you were involved. You will be asked to evaluate your treatment, in writing, during or upon completion of treatment.

AGENCY RESPONSIBILITIES

In addition to protecting client's rights, Union County Counseling Services, Inc. maintains responsibility for:

1. Assigning a therapist, counselor, case manager, and agency physician.
2. Deciding on the mode of treatment.
3. Assigning the frequency and duration of client involvement
4. Involving family members or significant others in treatment when appropriate.
5. Maintaining an accurate clinical record.
6. Making referrals to other service agencies.
7. Billing for services either directly, or through insurance or other third-party payees.
8. Defining criteria for termination of services.
9. Communicating with Courts or responsible officials thereof, as mandated by Statute, Rule, or Court decision.

PROTECTED RIGHTS

Union County Counseling Services shall ensure the following rights are protected in accordance with Chapter 2 of THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE.

1. The use of seclusion shall not be permitted.

2. You have the right to remain in treatment unless you voluntarily withdraw or meet criteria for termination.

3. You have the right to contact the Guardianship and Advocacy Commission, Equip for Equality, Inc., Human Rights Authority, Department of Human Services – Office of Mental Health, Department of Public Health**,** and Department of Children and Family Services.

The following are the address and telephone numbers to these agencies:

Guardianship and Advocacy	Equip for Equality, Inc.	Human Rights Authority	Dept. of Public Health
#7 Cottage Drive	1-800-758-0464	#7 Cottage Drive	2309 W. Main
Anna, IL 62906		Anna, IL 62906	Marion, IL 62959
618-833-4897		618-833-4897	1-800-252-4343

Department of Human Services	DCFS	Office of Inspector General
401 William Stratton Bldg.	Industrial Drive, 108 Denny	901 Southwind Road
Springfield, IL 62765	Anna, IL 62906	Springfield, IL 62703
217-785-6023	618-833-4449	217-786-0019
	800-252-2873	800-368-1463

4. This information will be given to you or your guardian in a language you understand.

5. Staff advisement of your rights and justification for any restriction of your rights will be documented in your record.

6. Every individual in treatment shall be free from abuse and neglect.

7. You or your guardian shall be permitted to purchase and use the services of private physicians and other mental health and developmental disabilities professionals of your choice. This shall be documented in your services plan.

8. You shall not be denied, suspended, or terminated from services or have services reduced for exercising any of your rights.

Rev. 9/13 HIPAA Compliance
Rev. 10/10
Rev. 08/09
Rev. 04/09
Rev. 12/07
REV: 12/06
REV: 8/04
REV: HIPAA Compliance 4/03
REV: 10/31/00