TAB 35
Notice of Privacy Practices

See attached

DE PAUL FAMILY AND COMMUNITY SERVICES NOTICE OF PRIVACY PRACTICES

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.

Who We Are

This Notice describes the privacy practices of DePaul Family and Community Services ("FCS" "we" or "us"), including:

- All psychologists and other healthcare professionals allowed to enter or access information in your medical record
- All employees with access to your medical or billing records or other protected health information about you ("Protected Health Information").
- Any volunteers, trainees and other personnel authorized to help you while you are at our office.

Our Privacy Obligations

We understand that your health information is personal and we are committed to protecting your privacy. In addition, we are required by law to maintain the privacy of your Protected Health Information, to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information, and to notify you in the event of a breach of your unsecured Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Permissible Uses and Disclosures Without Your Written Authorization

We may use and disclose your Protected Health Information without your authorization for the following purposes unless the Protected Health Information is a sensitive type of information protected by applicable state or federal law ("Highly Confidential Information") and the applicable law imposes special restrictions on us. If a law requires us to obtain your consent or authorization to use your information for a purpose, we will obtain your written consent or authorization before using the information for that purpose. We describe activities that require consent or authorization in the next section of this Notice.

Treatment. We use and disclose your Protected Health Information to provide group, family, couple and play therapy, psychiatric assessments, advocacy, and case management and other treatment services to you. We may use your information to direct or recommend alternative treatments, therapies, health care providers, or settings of care to you or to

describe a health-related product or service. We may also disclose Protected Health Information to coordinate care with other providers involved in your treatment or in a medical emergency. We may contact 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.

Payment. We will obtain your written consent to disclose information about therapy or other services when required by the Illinois Mental Health and Developmental Disabilities Confidentiality Act. With your written consent, we may use and disclose your Protected Health Information to obtain payment for health care services that we provide to you--for example, disclosures to obtain payment from Medicaid, your health insurer, HMO, or other third party that pays the cost of your health care ("Your Payor") or to verify that Your Payor will pay for the health care.

Health Care Operations. We may use and disclose your Protected Health Information for our health care operations, which include (1) assessing the care and outcomes in your case and others like it, (2) improving the quality and effectiveness of the services we provide, (3) evaluating our therapists for performance, training, accreditation, certification, licensing or credentialing activities, and (4) general administrative activities. We may also disclose your Protected Health Information to a vendor that assists us with our operations and agrees to protect your Protected Health Information under a business associate agreement.

Disclosure to Personal Representatives. We may disclose your Protected Health Information to a parent of a minor patient, a guardian or other individual who is your personal representative under Illinois law.

As Required by Law. We may use and disclose your Protected Health Information when required to do so by any applicable federal, state or local law.

Public Health Activities. We may disclose your Protected Health Information: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to a government authority authorized by law to receive such reports; (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; and (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

Health Oversight Activities. We may disclose your Protected Health Information to U.S. Department of Health and Human Services, the Illinois Department of Human Services and certain other government agencies that oversee the health care system and are charged with responsibility for ensuring compliance with the rules of government health programs.

Judicial and Administrative Proceedings. We may disclose your Protected Health Information in the course of a judicial or administrative proceeding in response to a court order, subpoena or other lawful process. If we receive a request for information about mental health or developmental disability services, we will also comply with requirements under the Illinois Mental Health and Development Disabilities Confidentiality Act.

Law Enforcement Officials. We may disclose your Protected Health Information to the police or other law enforcement officials as permitted by law or in compliance with an appropriate court order.

Victims of Abuse, Neglect or Domestic Violence. We may disclose your Protected Health Information if we reasonably believe you are a victim of abuse, neglect or domestic violence to a government authority authorized by law to receive reports of such abuse, neglect, or domestic violence.

Health or Safety. We may use or disclose your Protected Health Information to prevent or lessen a serious and imminent threat to a person's health or safety. If a patient makes a specific threat of violence against a person, we may disclose mental health or developmental disability information to warn or protect the person.

Specialized Government Functions. We may use and disclose your Protected Health Information to certain units of the government with special functions, such as the U.S. military or the U.S. Department of State under circumstances authorized by law.

Research Activities. Under certain circumstances, your Protected Health Information may be disclosed for research purposes. We may use and disclose your Protected Health Information for research purposes pursuant to a valid authorization from you or when our institutional review board has waived the authorization requirement. Under certain circumstances, your Protected Health Information may be disclosed without your authorization to researchers preparing to conduct a research project, for research on decedents or as part of a data set that omits your name and other information that can directly identify you.

Decedents. We may disclose Protected Health Information about a patient to a coroner conducting a preliminary investigation into a patient's death as authorized by law.

Workers' Compensation. We may disclose your Protected Health Information as authorized by and to the extent necessary to comply with Illinois law relating to workers' compensation or other similar programs.

Uses and Disclosures Requiring Your Written Authorization or Consent

For any purpose other than the ones described in the Section above, we only use or disclose your Protected Health Information when you give us your written authorization.

Your Highly Confidential Information. If you receive therapy, psychiatric assessments or other mental health or developmental disability services from us, we will only use or disclose the information in accordance with the Illinois Mental Health and Development Disabilities Confidentiality Act. If the Act requires us to obtain your consent for a use or disclosure of your information, we will comply with the Act.

We will not use or disclose psychotherapy notes about you without your authorization except for use by the therapist or other mental health professional who

created the notes to provide treatment to you, for our mental health training programs or to defend ourselves in a legal action or other proceeding brought by you.

In addition, we will comply with federal and state laws that require special privacy protections for other types of highly confidential health information if we maintain the information about you. If a law requires us to obtain your authorization to use or disclose your highly confidential information for an activity, we will obtain your authorization or not use or disclose the information for the activity.

Marketing; Sale of PHI. We must obtain your written authorization prior to using your Protected Health Information for purposes that are marketing under the HIPAA privacy rules unless the marketing communication is part of a face-to-face communication with you or in our office. We will not accept any payments from other organizations or individuals in exchange for making communications to you about treatments, health care providers, care coordination, products or services unless you have given us your authorization to do so or the communication is otherwise permitted by law. In addition, we will not make any disclosure of Protected Health Information that is a sale of Protected Health Information under HIPAA without your written authorization.

Revocation of Your Authorization or Consent. You may revoke your authorization or consent, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below.

Your Individual Rights

For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your Protected Health Information, you may contact our Privacy Office. You may also file written complaints with the Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Office for Civil Rights. We will not retaliate against you if you file a complaint with us or the Office for Civil Rights.

Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your Protected Health Information for treatment, payment and health care operations and other purposes. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction unless the request is to restrict our disclosure to a health plan for purposes of carrying out payment or health care operations, the disclosure is not required by law and the information pertains solely to a health care item or service for which you (or someone on your behalf other than the health plan) have paid us out of pocket in full. We also comply with restrictions required by the Illinois Mental Health and Development Disabilities Confidentiality Act. If you wish to request additional restrictions, please obtain a request form from our Privacy Office and submit the completed form to the Privacy Office. We will send you a written response.

Right to Confidential Communications. You may request, and

we will accommodate, any reasonable written request for you to receive your Protected Health Information by alternative means of communication or at alternative locations.

Right to Access Your Health Information. You have the right to look at or get copies of your medical record file and billing records maintained by us. A parent or guardian may obtain access to mental health or developmental disability service records of patient under 12 years old. A parent or guardian may obtain access to a patient who is at least 12 years old and under 18 years old only if the patient is informed and does not object to the access or the patient's therapist does not find that there are compelling reasons for denying access. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Privacy Office and submit the completed form to the Privacy Office. You may also request access by sending a letter requesting access to our Privacy Office at the address below. If you request copies, we may charge you a cost-based copy fee.

Right to Amend Your Records. You have the right to request that we amend your Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Office. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us during any period of time prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a 12 month period, we may charge you a reasonable fee for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

Effective Date and Duration of This Notice

This Notice is effective on August 1, 2017. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all your Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in our waiting room and on our Internet site at www.csh.deapul.edu. You also may obtain any new notice by contacting the Privacy Office.

Privacy Office

You may contact the Privacy Office at:

DePaul Family and Community Services
2219 N. Kenmore Ave., Suite 300
Chicago, Illinois 60614

Attention: FCS Business Manager
Telephone Number: (773)325-7788
E-mail: DePaulFCS@depaul.edu

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices of DePaul Family and Community Services and consent to the uses and disclosures described in the Notice of Privacy Practices.

By: _____ _____ __, 20__
Signature of Patient (or Personal Representative) Date of Signature

_____
Printed Patient Name

Instruction: Please provide the following information if the patient's parent or other personal representative will sign this acknowledgement. The patient must be at least 12 years old to sign the acknowledgment.

_____
Printed Name of Personal
Representative (*if applicable*)

_____
Relationship of Personal Representative to Patient
(*if applicable*)