



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.

Effective Date: April 14, 2003 and modifications as of May 23, 2019.

We respect patient confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by Chaddock. In addition all rights identified in Chaddock Procedure **ORG 5.01 Client Privacy Rights Procedure** and **ORG 5.03 Client Rights Procedure** apply.

Privacy Contact/Privacy Officer. If you have any questions about this policy or your rights contact (217) 222-0034 ext. 397

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 beyond Chaddock. This includes for:

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 Chaddock that we are consulting with or referring you to.

Payment. With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company 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 to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff and program evaluation. This may also include evaluation of and research on the treatment programs in which you participate.

Illinois Health Practice Alliance. Covered Entity participates with other behavioral health service agencies (each, a "Participating Covered Entity") in the IPA Network established by Illinois Health Practice Alliance, LLC ("Company") Through Company, the Participating Covered Entities have formed one or more organized systems of health care in which the Participating Covered Entities participate in joint quality assurance activities, and/or share financial risk for the delivery of health care with other Participating Covered Entities, and as such qualify to participate in an Organized Health Care Arrangement ("OHCA") as defined by the Privacy Rule. As OHCA participants, all Participating Covered Entities may share the PHI of their patients for the Treatment, Payment and Health Care Operations purposes of all of the OHCA participants.

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 voicemail 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, Funeral Directors, and Organ Donation. We are required to disclose information about the circumstances of your death to a coroner who is investigating it.

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 U.S. 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 someone.

CLIENT RIGHTS

You have the following rights under Illinois and federal law:

Copy of Record. You are entitled to inspect your the medical record Chaddock has generated about you. We may charge you a reasonable fee for copying and mailing your record.

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 on Record. You may ask us not to use or disclose part of the medical information. This request must be in writing. Chaddock 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.

Client Name: _____
Client DOB: _____

Amending Record. 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** and ask for the *Request to Amend Health Information* form. 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. Please submit your request in writing to our **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 submit a complaint to the Secretary of U.S. Department of Health and Human Services if you believe Chaddock has violated your privacy rights. We will not retaliate against you for filing a complaint.

Privacy complaints may be directed to any of the following:

Illinois Department of Human Services main offices:

100 South Grand Avenue 401 South Clinton Street
Springfield, IL 62762 Chicago, IL 60607

U.S. Department of Health and Human Services, Office for Civil Rights

Medical Privacy, Complaint Division
200 Independence Avenue, SW
HHS Building, Room 509H
Washington, D.C. 20201
Phone: 866-627-7748
TTY: 886-788-4948

E-mail: www.hhs.gov/ocr

The Notice of Privacy Practices have been explained to _____
in their primary language of _____.

_____ _____
Admissions Personnel Signature/Witness Date

I acknowledge receiving an explanation and a copy of the Notice of Privacy Practices.

_____ _____
Clients Signature (12 years or older) Date
 Own Guardian

Copy received Copy declined

_____ _____
Guardian Signature Date

Copy received Copy declined
 Guardian notified of need for signature.
Date: _____