**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. Gramercy Specialty Clinic understands that your medical information and your health are personal. We are committed to protecting your medical information and are required by law to protect medical information about you.**

**HOW WE MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU**

The following describes different ways we use and disclose your medical information.

* **For Treatment:** We may use your medical information to provide healthcare treatment and behavioral health services to you. We may share your medical information with necessary medical and treatment personnel to coordinate your ongoing care.
* **For Payment:** We may use and disclose your medical information so that the treatment and services you receive may be billed and payment may be collected from appropriate payors, such as an insurance company or a third party.
* **For Health Care Operations:**  We may use and disclose your medical information for business activities. These uses and disclosures are necessary for administrative functions and to ensure our clients receive quality care.
* **Individuals Involved in Your Care:** We may release information relevant to your treatment to a family member; parent/guardian for minors; close personal friend; or others who you identify as being actively involved in your care to the extent allowed under state law and Providence Human Services policies and procedures. You may request that we don’t disclose information to those involved in your care and we will comply with your request except under limited circumstances such as emergency situations.

# Substance abuse health information and HIV information: All medical information regarding substance abuse and HIV is kept strictly confidential and released only in conformance with the requirements of federal law (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3) and regulation (42 C.F.R. part 2). Disclosure of any medical information referencing alcohol or substance abuse treatment or HIV may only be made with your written authorization.

* **Public Health and Safety for you and/or others:**  We may use or disclose medical information about you if it is necessary to prevent or control disease, injury, or disability; report abuse/neglect/domestic violence; report reactions to medications; prevent or report exposure to disease; or prevent a serious threat to public safety.
* **Health Oversight Activities.**  We may disclose your medical information to a health oversight agency for activities authorized by law.
* **Court Proceedings:** We may disclose your medical information in response to a valid court or administrative order, a valid subpoena or other lawful process that complies with state law as well as Providence Human Services policies and procedures.
* **Law Enforcement.** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. We will not release your medical information to a law enforcement official except in response to a valid court order, subpoena, warrant, summons, or similar lawful process that complies with state law and Providence Human Services policies and procedures.
* **Coroners, Medical Examiners and Funeral Directors.** We may release your medical information to a coroner, medical examiner, or organization that manages organ donations. This may be necessary for purposes of identification; to determine a cause of death; or to assist with organ transplants.
* **Worker’s Compensation:** We may disclose medical information about you in order to comply with worker’s compensation laws.
* **Certain Government Functions:** We may use or disclose medical information about you to authorized federal officials for certain government functions including military, veterans, national security, and intelligence activities as authorized by law.
* **Protective Services for the President and Others.** We may disclose your medical information to authorized federal officials so they may provide protection to the President or other authorized persons.
* **As Required By Law.** We may disclose your medical information when required to do so by federal, state, or local law.

**OTHER USES AND DISCLOSURES**

**Authorizations**

Other uses and disclosures of your medical information not covered by this notice will be made only with your written authorization. If you provide us with written authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke, we will no longer use or disclose your medical information for the reasons covered by the authorization.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

* **Right to a Copy of This Notice**: You have a right to a paper copy of this Notice of Privacy Practices.
* **Right to Access:** You have the right to inspect and receive a copy of medical information about you that we maintain in records.
* **Right to Amend:** If you feel that your medical information is incorrect or incomplete, you have the right to request an amendment for as long as your medical information is kept by us..
	+ **Right to an Accounting of Disclosures:** You have the right to receive an accounting of disclosures of your medical information. This is a list of disclosures we made of your medical information to others. This does not include disclosures made for treatment, payment, or healthcare operations, or those that were authorized by you in writing.
	+ **Right to Request Restrictions:** You have the right to request a restriction on the medical information we use or disclose about you for treatment, payment, or healthcare operations. We must comply with this request if it meets certain requirements.
	+ **Right to Request an Alternative Method of Contact:** You have the right to request that we communicate with you about medical matters through a specific method or at a certain location.
	+ **Right to Notification if a Breach of Your Medical Information Occurs:** You have the right to be notified in the event of a breach of medical information about you.
	+ **Right to Opt-Out of Fundraising Communications:** You have the right to opt-out of receiving fundraising communications from us.

**CHANGES TO THIS NOTICE**

We reserve the right to change this Notice and to make the revised notice effective for all of your medical information that we maintain as well as any information we receive following the revision. We will inform you of any changes to our privacy practices.

**COMPLAINTS**

If you believe your privacy rights have been violated, you have the right to file a written complaint with the United States Secretary of the Department of Health and Human Services through the Office for Civil Rights, US Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.Telephone: (202) 619-0257. The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

**We will not take any action against you or change our treatment of you in any way if you file a complaint.**

A full Notice of Privacy Practices is available at all office locations.

**Notice of Privacy Practices**

**Acknowledgment of Receipt**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** hereby acknowledge that I have received a copy

 ***Client’s Name***

of the Notice of Privacy Practices (“Notice”).

The information in this Notice has been explained to me, and I understand that I may ask questions about the Notice and my rights at any time.

The Notice tells me how the clinic will use my health information for the purposes of my treatment, payment for my treatment, and the clinic’s health care operations.

The Notices explain in more detail how the clinic will use may use and share my health information for other than treatment, payment and health care operations.

The clinic will also use and share my health information as required/permitted by law.

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 **Client’s Signature Date**

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 **Client’s Printed Name**

***\*\*If the client is a minor or a person who has a legal guardian, that legal guardian must sign below.\*\****

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 **Legal Guardian Signature**

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**Printed Name of Person Signing Above & Title if Legal Representative**

**(e.g. Parent, Guardian, Legal Conservator)**

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 **Staff Signature & Title Date**