Notice of Privacy Practices

Effective Date: April 14, 2003
Revised Date: February 1, 2024

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

1. Our Commitment to You: We at the Mental Health Association of Nassau County, Inc. (MHANC) understand that the information we collect about you and your health is personal. Keeping your health information confidential and secure is one of our most important responsibilities. We keep a record of the care and services that you receive at this Agency. We need this record to provide you with quality care and to comply with certain legal requirements. We are committed to protecting your health information (PHI) and to following all state and federal laws regarding the protection of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of Privacy Practices with respect to health information about you (a copy of the current Notice of Privacy Practices will always be posted in the reception area of each site, if applicable, or in surrounding areas in which it is visible to you. You may also obtain a copy of this Notice by accessing our website at www.mhanc.org or by requesting a copy from program staff.
- Follow the terms of the Notice that is currently in effect
- Notify you following a breach of your unsecured health information

2. How we may Use and Disclose Health Information about you: For some activities, we must have your written authorization to use or disclose your health information, including your psychotherapy notes, for marketing purposes, or involving the sale of your PHI. However, the law permits MHANC to use or disclose your health information for the following purposes ***without*** your authorization:

- For Treatment and Payment for Treatment: If an individual pays out-of-pocket for a service, the individual has the right to request PHI information related to that service not be disclosed as long as not otherwise required by law.
- For Health Care Operations
- For other Government Agencies providing Benefits or Services
- When Required by Law
- In response to Lawsuits and Disputes
- For Law Enforcement, Coroners, Medical Examiners and Funeral Directors
- Organ Donation
- For National Security and Protection of the President
- For the Military
- For Health Oversight Activities
- If information is completely or partially de-identified
- Inmates and Correctional Institutions
- Emergencies

- To Avert a Serious Health or Safety Threat
- For Public Health Risks
- Disclosure to family or friends involved in your care as long as you an opportunity to verbally object
- Business Associates
- Product Monitoring, Repair, and Recall
- Research
- National Security and Intelligence Activities or Protective Services
- Workers Compensation
- Victims of Abuse, Neglect, or Domestic Violence
- If a Health Plan intends to use or disclose PHI for underwriting purposes, a statement that the covered entity may not use or disclose genetic information for such purposes
- Fundraising: To support MHANC's business operations, we may use demographic information about you, including information about your age and gender, when deciding whether to contact you or your personal representative to raise money to help us operate. We may also share this information with a charitable foundation that will contact you or your personal representative to raise money on our behalf. You have a right to opt out of receiving such communications.
- The ability of a group health plan, or health insurance issuer or HMO with respect to a group health plan, to disclose PHI to the sponsor of the plan

3. I understand that photographs, videotapes and digital, or other images may be recorded to document my care, and I can consent to this. I understand that MHANC will retain the ownership rights to these photographs, videotapes, digital or images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in MHANC policy. Images that identify me will be released and/or used outside the institution ***only upon written authorization*** from me or my legal representative. ***Note: This consent does not authorize the use of the images for other purposes, such as teaching or publicity.*** HIPAA requires consumer authorization for the release of PHI, which includes consumer photography, ***for purposes beyond*** treatment, payment, and health care operations.

4. Your Health Information Rights: You have the following rights regarding health information we have about you:

- RIGHT to request an opportunity to Inspect and obtain Copies (we will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days. If we need additional time to respond to a request for copies, we will notify you in writing within 30 days from the day we receive the request to explain the reason for the delay and when you can expect to have a final answer to your request, which will not be more than 60 days if the information is off-site).

- RIGHT to request access to your electronic health record (Foothold's AWARDS or Foothold Care Management)
- RIGHT to request an opportunity to Amend your health information
- RIGHT to receive an Accounting of Disclosures we have made
- RIGHT to request Restrictions in the disclosure of your health information (we are generally not required to agree to your request for a restriction, except we must agree to your request to restrict the information we provide to your health plan if the disclosure is not required by law and the information relates to health care being paid in full by someone other than the health plan, and in some cases, the restriction you request may not be permitted under law. If we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction)
- RIGHT to request Confidential Communications from us to you
- RIGHT to receive a full and complete paper or electronic copy of this Notice

If you would like to exercise one or more of these rights, speak to a staff member in the program in which you are receiving services, or contact the Compliance/Quality Improvement Department at (516) 489-2322, extension 1234.

If you do not object - and the situation is not an emergency - and disclosure is not otherwise prohibited by stricter laws, we are permitted to release your health information under the following circumstances:

- **To Individuals involved in Your Care:** We may release your health information to a family member, relative, friend, or other person who you have identified to be involved in your health care or for the payment of your health care.
- **To Family:** We may use your health information to notify a family member, a personal representative, or a person responsible for your care of your location, general condition, or death.
- **To Disaster Relief Agencies:** We may release your health information to an agency authorized by law to assist in disaster relief efforts.

5. What is NOT Covered under this Notice

- **Confidential HIV-Related Information:** Under New York State Law, confidential HIV-related information (information concerning whether or not you have had an HIV- related test, or have HIV infection, HIV-related illness, or AIDS, or which could indicate that a person has been potentially exposed to HIV), cannot be disclosed except to those people you authorize in writing to have it.
- **Alcohol or Substance Abuse Treatment Information:** If you have received alcohol or substance abuse treatment from an alcohol/substance abuse program that receives funds from the United States government, federal regulations may protect your treatment

records from disclosure without your written authorization.

- **Genetic Information:** If your treatment involves Genetic information, you will be provided with a separate Notice explaining how this information will be protected.
- Any uses and disclosures not described in this Notice of Privacy Practices will only be made with prior authorization.

6. For More Information or to Report a Problem:
If you have any questions about this Notice or if you believe your privacy rights have been violated, you may request information or file a complaint with the agencies listed below. There will be no penalty or retaliation for filing a complaint:

The Office for Civil Rights
Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312
New York, New York 10278
Telephone: (212) 264-3313 or 1-(800)368-1019
Fax: (212) 264-3039
TDD: (212) 264-2355

Secretary of the Department of Health and Human Services (HHS)
200 Independent Avenue SW
Washington, D.C. 20201
1-(877) 696-6775

Federal Relay Services
1-(800) 877-8339

To file a complaint directly with us, please contact:

Lisa Weiss, LMSW, CHC, CHPC
Compliance Officer/Director of Compliance and Quality
Improvement/HIPAA Privacy Officer
16 Main Street
Hempstead, NY 11550
(516) 489-2322, extension 1234

MHANC
MENTAL HEALTH ASSOCIATION
OF NASSAU COUNTY

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have received this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Mental Health Association of Nassau County, Inc. (MHANC). In addition, this Notice has informed me how I may obtain access to my health information, that I may request that my documented health information be amended, and how I may restrict the disclosure of my health information. I have the right to request a copy of this Notice should I wish to have one.

_____

Signature of Consumer or Personal Representative (if applicable)

_____

Print Name of Consumer or Personal Representative (if applicable)

_____

Date

_____

Description of Personal Representative's Authority (if applicable)

☐ Consumer refuses to acknowledge that he/she received this Notice of Privacy Practices; however, a copy has been offered to consumer

Staff Signature: _____ Date: _____