

## 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.

### **Obligations of The Provider**

Jewish Association for Services for the Aged (JASA) Mental Health Services<sup>1</sup> (“Provider”) will follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003. This notice will remain in effect until it is revised or replaced.

We are required to:

- maintain the privacy of protected health information;
- provide you with this notice of our legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice or the notice currently in effect;
- comply with certain objections you may have with regard to our use and disclosure of your health information as specified herein;
- comply with requirements regarding your individual rights as specified herein; and
- obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows it. We reserve the right to make these changes effective for all health information that we maintain, including health information we created or received before the changes were made. Before we make a significant change in our privacy practices, we will revise this notice and send the new notice to you at the time of the revision. You may request a copy of our Notice of Privacy Practices at any time.

### **Use or Disclosures of Health Information**

*Treatment.* We may use and disclose your health information without your authorization to provide your health care and any related services. We may also use and disclose your health information to coordinate and manage your health care and related services. We may disclose your health information among our clinicians and other staff (including clinicians other than your therapist) who work at JASA MENTAL HEALTH SERVICES. For example, our staff may discuss your care at weekly team meetings.

*Payment.* We may use and disclose your health information without your authorization so that the treatment and services you receive are billed to, and payment is collected from, your health

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<sup>1</sup> All references to JASA Mental Health Services refers to two programs at JASA: Geriatric Mental Health Outreach Services (GMHOS)-1 Fordham Plaza, Ste. 232, Bronx, NY 10458 and Geriatric Mental Health Outreach Manhattan Satellite (GMHOMS)- 132 W 31<sup>st</sup> Street, 10<sup>th</sup> Fl. NY, NY 10001

plan or other third party payer. For example, we may disclose your health information to permit your health plan or payer to review your services to ensure the appropriation of your care, or to justify the charges for your care.

*Health Care Operations.* We may use and disclose health information about you without your authorization for our health care operations. These uses and disclosures are necessary to run our organization and make sure that our consumers receive quality care. These activities may include, by way of example, contacting you by phone or home visit within 24 hours of a missed appointment.

*Authorization.* You may give us written authorization to use your health information or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time. Unless you give us a written authorization, we will not use or disclose your health information for any reason except those described in this notice.

*Communication to Individuals Involved in Your Care.* Your health information may be used or disclosed by us to notify or communicate to your family members or other persons involved in your care. Unless you object and inform us of your objection, your health information may be released to a family member, close personal friend or other person who is involved in your care to the extent necessary for such persons to participate in your care. Please contact our Privacy Officer using the contact information at the end of this notice if you want uses and disclosures regarding your health information to individuals involved in your care to be limited any way.

*Required by Law.* We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence;
- to assist law enforcement officials in their law enforcement duties; and
- to determine your eligibility for benefits provided by the Department of Veteran Affairs.

*Public Health.* Your health information may be used or disclosed for public health activity such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. We may also disclose your health information to a health oversight agency (New York State Office of Mental Health and New York City Department of Mental Health and Hygiene) for activities authorized by law.

*Decedents.* Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

*Organ Tissue Donation.* Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

*Health and Safety.* Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

*Research.* We may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

*Government Functions.* Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

*Workers Compensation.* Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

*Emergencies.* We may use and disclose your health information in an emergency treatment situation. By way of example, we may provide your health information to a paramedic who is transporting you in an ambulance.

### **Your Individual Rights**

*Access.* You have the right to inspect or obtain copies of your health information, with some exceptions. Usually, this would include clinical and billing records, but not psychotherapy notes. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical to do so. To obtain a copy of your health information, you must make a request in writing. If you request copies, you may be charged a reasonable fee, including the cost of copying and postage. You may make a written request to our Privacy Officer for your health information, using the contact address at the end of this notice.

*Accounting.* You have the right to receive an accounting in which we or our business associates used or disclosed your health information for purposes other than treatment, payment, health care operations, as authorized by you, or for certain other activities, on or after April 14, 2003. To obtain a copy of an accounting, you must make a request in writing to our Privacy Officer using the contact address at the end of this notice.

*Amendments.* You have the right to request that we amend your health information. Usually this would include clinical and billing records but not psychotherapy notes. Your request must be in writing and it must explain why we should amend the information. We may deny your request if we did not create the information you want amended or we may deny your request for other reasons. If we deny your request, we will send you a written explanation. You may respond with a statement of disagreement that we will add to the information you want amended. To request an amendment, you must make a written request to our Privacy Officer using the contact address at the end of this notice.

*Confidential Communications.* You have the right to request that we communicate with you about your health information by other means or to other locations. You must make your request in writing using the contact address at the end of this notice. We must accommodate your request if it is reasonable.

*Restrictions.* You have the right to request that we place additional restrictions on our use or

disclosure of your health information. We are not required to agree to those additional restrictions, but if we do, we will abide by our agreement except in emergency situations. To request restrictions, you must make a request in writing using the contact address at the end of this notice. Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement for us.

### **Questions and Complaints**

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you think that we may have violated your privacy rights or you disagree with a decision we made about your privacy rights, you may file a complaint with us using the contact information listed below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint.

#### Contact Information.

Privacy Officer  
Ilana Dunner  
JASA  
132 W. 31<sup>st</sup> Street  
10<sup>th</sup> Floor  
New York, NY 10001

Acknowledgment Of Receipt Of Notice Of Privacy Practices

I, \_\_\_\_\_, acknowledge that I have received a copy of Jewish Association for Services for the Aged (JASA) Mental Health Services' Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient / Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Patient's Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

If Acknowledgment could not be obtained, explain the circumstances:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Job Title