MENTAL HEALTH CENTER
of AMERICA

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

"This notice describes how your personal and medical information that you provide us may be used and disclosed and how you can get access to this information, please review it carefully"

Confidentiality Practices
The Arizona Department of Economic Security (DES) is committed to protecting your Personal Identifying Information (PII) and Protected Health Information (PHI). This notice explains how DES will use, share, and protect your PII and PHI. It also explains your rights to privacy of your PII and PHI as required by law. DES can change the terms of this notice, and the changes will apply to all information we have about you. The revised notice will be posted to our web site and will be provided to you on request.

Collection, Storage, and Disposal of PII and PHI
The DES and its programs will identify and collect the minimum PII and PHI data elements that are relevant and necessary to conduct the business functions it is legally authorized to perform. It will review the use of the PII and PHI data elements annually to ensure that only the necessary data is collected and stored for business purposes. Your PII and PHI will be stored in our computer systems and paper files, if necessary, according to State and Federal retention laws. Access to these computer systems is restricted based on a person's job functions and role within the organization.

Uses, Sharing, and Protection of PII and PHI
The law only allows our staff to use your PII and PHI when doing their jobs or to share your information when it is necessary to run the program. When PII and PHI is shared with other agencies or organizations, DES requires them to keep your PII and PHI confidential. Your PHI will be shared to approve or deny treatment, and to determine if you are getting the right medical treatment. For example, doctors and nurses employed by the programs may review the treatment plan created for you by your health care provider to make sure the care you receive is medically necessary.

The Program Will Use and Share Your PHI Without Authorization to:

- Make payments to your health care providers for medical services provided to you.
- Coordinate payment for your care between the program, other health plans, and other insurance companies that may be responsible for the cost of your care.
- Coordinate your care between the program, other health plans, and health care providers to improve the quality of your health care.
- Evaluate the performance of your health care provider. For example, the program contracts with consultants to review hospital and other facilities' medical records to check on the quality of care you received.

- Release information to its attorneys, accountants, and consultants so that the program is run efficiently and to detect and prosecute program fraud and abuse.
- Send you helpful information such as program benefit updates, free medical exams, and consumer protection information.
- Share information with other government agencies or organizations that provide benefits or services when the information is necessary in order for you to receive those benefits or services.

The Program May Disclose Your PHI Without Authorization:

- To public health agencies for activities such as disease control and prevention, problems with medical products or medications.
- If you are the victim of abuse, neglect or domestic violence.
- To health oversight agencies responsible for the Medicaid Program such as the U.S. Department of Health and Human Services and its Office of Civil Rights.
- In court cases or judicial and administrative hearings when required by law to run the program.
- To coroners, medical examiners, and funeral directors so they can carry out their jobs as required by law.
- To organizations involved with organ donation and transplantation, communicable disease registries and cancer registries.
- To entities authorized to conduct a research project.
- To prevent a serious threat to a person's or the public's health and safety.
- To the military if you are or have been a member of the armed services.
- To a correctional facility or law enforcement officials to maintain the health, safety, and security of the corrections systems, if you are held in custody.
- To workers' compensation programs that provide benefits for work-related injuries or illness without regard to fault.
- To law enforcement or national security and intelligence agencies, and to protect the President and others as required by law.

Uses and Disclosures of Protected Information Based on Your Written Authorization

All other uses and disclosures will be made only with your written authorization. These may include:

- Most uses and disclosures of your psychotherapy notes will require your authorization.
- Any use or disclosure for marketing purposes will require your authorization.
- Any use or disclosure that would constitute a sale of your information will require your authorization.

Your Other Rights Concerning Your PII and PHI Includes the Right to:

- See and get copies of your records. You may be charged a fee for the cost of copying your records.
- Request to have your records amended or corrected if you think there is a mistake. You must provide a reason for your request.
- Receive a list of disclosures. This list will not include the time that information was disclosed for treatment, payment or health care operations covered under the law. The list will not include information provided to you or your family directly, or information that was sent with your authorization.

- Further restrict uses and disclosures of your PII and PHI. You must tell DES what information you want to limit and to whom you want the limits to apply. DES is not required to agree to the restriction.

- Cancel authorizations previously provided by you to DES. This cancellation, however, will not affect any information that has already been shared.
- Receive a written notification in the event of a breach of your protected information.
- Choose how the program communicates with you in a certain way or at a certain place.
- Opt out of receiving fundraising communications.
- File a complaint if you do not agree with how DES has used or disclosed information about you.
- Receive a paper copy of this notice at any time.

ANY REQUEST YOU MAKE TO DES MUST BE IN WRITING
How to Contact DES Regarding Your Privacy Rights:

- Mail all written forms, requests and correspondence to:
- Arizona Department of Economic Security
- Chief Privacy Officer
- Mail Drop 1292
- 1789 W. Jefferson
- Phoenix, AZ 85007
- The Privacy Officer may deny your request to look at, copy or change your records. If DES denies your request, DES will send you a letter that tells you why your request is being denied and if you can request a review of that denial.

How to File a Complaint:
- You may file a complaint with DES or the U.S. Department of Health and Human Services-Office of Civil Rights:
- *(You will not be retaliated against for filing a complaint)*
- Send correspondence to:
- Arizona Department of Economic Security
- Chief Privacy Officer
- Mail Drop 1292
- 1789 W. Jefferson
- Phoenix, AZ 85007
- **OR**
- ***For HIPAA Complaints involving PHI***
- Department of Health and Human Services
- 200 Independence Avenue, SW
- HHH Building, Room 509F
- Washington, D.C. 20201
- ***For Privacy Complaints involving PII*** HHS Privacy Act Officer 200 Independence Avenue, SW HHH Building - Suite 729H Washington, D.C. 20201
- **For More Information:**
- If you have any questions about this notice or need more information, please contact the DES Privacy Officer. DES may change its Notice of Privacy Practices. Any changes will apply to information DES already has, as well as any information DES may get in the future. A copy of any new notice will be

posted at the DES HIPAA Administration Office as well as its web site. You may ask for a copy of the current notice at any time, or get it on-line at https://des.az.gov/

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: _____

Patient Name (Printed): _____