YOUTH DYNAMICS

NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: April 14, 2003

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.

Youth Dynamics, Inc (YDI) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices or have complaints about how your health information has been handled at Youth Dynamics, Inc. please contact:

HIPAA Privacy Officer
2334 Lewis Avenue
Billings, MT 59102
(406) 245-6539 FAX (406) 245-3192

I. How YDI may Use or Disclose Your Health Information

YDI collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of YDI but the information in the medical record belongs to you. YDI protects the privacy of your health information. The law permits YDI to use or disclose your health information for the following purposes:

1. Treatment We may use your Personal Health Information (PHI) to provide you with mental health-related services. We may use your information to coordinate care with other healthcare providers. For example: we may speak to other providers regarding your mental health treatment needs and progress.

2. Payment We may use and disclose your PHI in order to receive payment for the mental health services you receive. For example; we may speak to your insurance company, or the Medicaid office regarding an outstanding claim.

3. Regular Health Care Operations We may use and disclose PHI about you for our health care operations, which are activities necessary to operate Youth Dynamics Inc. to ensure that all of our clients receive quality care.

4. Information provided to you.

5. Notification and communication with family We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Required by law. As required by law, we may use and disclose your health information.

7. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

8. Health oversight activities We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

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9. Judicial and administrative proceedings We may disclose your health information in the course of any administrative or judicial proceeding.

10. Law enforcement We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

11. Deceased person information We may disclose your health information to coroners, medical examiners and funeral directors.

12. Public safety We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

13. Worker's compensation We may disclose your health information as necessary to comply with worker's compensation laws.

II. When YDI May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, YDI will not use or disclose your health information without your written authorization. If you do authorize YDI to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. YDI is not required to agree to the restriction that you requested.

2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. Written requests for Confidential Channel Communication are available at each YDI office. Payment may be required for unusual requests.

3. You have the right to inspect and copy your health information.

4. You have a right to request that YDI amend your health information that is incorrect or incomplete. YDI not required to change your health information and will provide you with information about our denial and how you can disagree with the denial.

5. You have a right to receive an accounting of disclosures of your health information made by YDI except that YDI does not have to account for the disclosures described in parts 1 (treatment), 2 (payment), 3 (health care operations), and 4 (information provided to you), of section I of this Notice of Privacy Practices.

6. You have a right to a paper copy of this Notice of Privacy Practices.

IV. Changes to this Notice of Privacy Practices

YDI reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, YDI is required by law to comply with this Notice.

V. Complaints

If you believe your privacy rights have been violated you may file a complaint with the YDI HIPAA Privacy Officer or with the Secretary of the Department of Health and Human Services.

Disclaimer: The information provided in this document does not constitute, and is no substitute for, legal or other professional advice. Users should consult their own legal or other professional advisors for individualized guidance regarding the application of the law to their particular situations, and in connection with other compliance-related concerns.

Acknowledgement of Receipt of Notice

Youth Dynamics, Inc., 2334 Lewis Avenue, Billings, MT 59102

Vicki Lapp, HIPAA Compliance Officer (406) 245-6539

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: ______________________________.

Signed: _______________________________ Date: ___________________________

Print Name: ___________________________ Telephone: ______________________

If not signed by the patient, please indicate.

Relationship:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: ____

***For Office Use Only*:**

❑ Signed form received by: _______________________________

❑ Acknowledgment refused:

Efforts to obtain:

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Reasons for refusal:

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Confidential Channel Communication Request

Youth Dynamics, Inc., 2334 Lewis Avenue, Billings, MT 59102

Vicki Lapp, Privacy Officer (406) 245-6539

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, ____________________ (*print name*) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

Please select all that apply.

❑ **Phone**

I want you to contact me by telephone at ____

❑ Do ❑ Do not leave messages on my answering machine.
❑ Do ❑ Do not leave messages with any other person.

❑ **Mail**

I want you to contact me at the following address: _____________________________________

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❑ **E-mail**

I want you to contact me at the following e-mail address: ________________________________

❑ **Fax**

I want you to contact me at the following fax number: __________________________________

❑ **Other requests for confidential communications** (specify)**.**
*** AM/PM - If this box is checked, sent to HIPPA OFFICER.**

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❑ Check here if you agree to reimburse this office for costs associated with this request. Any costs associated with this request will be explained to you before you are billed for them.

Signed: ____ Date: ________________________

Print Name: _____________________________________

If not signed by the patient, please indicate:
Relationship:
❑ Parent or guardian of minor patient
❑ Guardian or conservator of an incompetent patient
❑ Beneficiary or personal representative of deceased patient
❑ Other (specify)
Name of Patient: ____
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***For office use only*:**

Date Granted: __________________ Date Terminated or Modified: ________________

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