NOTICE OF PRIVACY PRACTICES
HIPAA

Anka Behavioral Health, Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Each time you participate in treatment with an Anka Behavioral Health, Inc., provider, a record is made. Typically, this record contains personal information including, but not limited to, a clinical history, mental health (and possibly, substance abuse) diagnosis, treatment plan, progress notes which describe our contact and interventions with you, a discharge plan and billing related information. This notice applies to, records of your treatment generated in this program, whether made by staff, agents of the program (such as office administration) or the psychiatrist. We are legally required to protect the privacy of this protected health information, or "PHI", for short.

This notice describes the information privacy practices followed by our employees, staff and office personnel in this program. Staff you may speak to will also follow the practices described in this notice on the telephone.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

This notice applies to the information and records we have about your health, health status, and the health care and service you receive at this office.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to other providers, office staff or other personnel who are involved in working with you in your treatment.

Different personnel in our program may share information about you and disclose information to people who do not work in the program in order to coordinate your treatment, such as phoning in prescriptions to your pharmacy or scheduling appointments. Family members and other health care providers may be part of

your treatment outside this program and may require information about you that we have.

For Payment We may use and disclose protected health information about you so that the treatment and services you receive at this program may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your PHI about a service you received so the county or funding source may have an accurate indication of all the services you have received.

For Treatment Operations We may use and disclose protected health information about you in order to run the program and make sure that you and our other clients receive quality care. For example, we may use your protected health information to evaluate the performance of our staff in providing services. We may also use protected health information about all or many of our clients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders We may contact you as a reminder that you have an appointment at the program.

Treatment Alternatives We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services We may tell you about treatment-related services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or services. If you advise us in writing (at the address listed on this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

Revocation of Consent

You may revoke your *Consent to Use or Disclose Health Information* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures, which occurred before that time.

If you do revoke your *Consent to Use or Disclose Health Information*, we will not be permitted to use or disclose information for purposes of treatment, payment or general office operations, and we may therefore choose to discontinue providing you treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law We will disclose protected health information about you when required to do so by federal, state or local law.

Research We may use and disclose protected health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security and Intelligence If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release protected health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose protected health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Oversight Activities We may disclose personal protected health information to a regulatory oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement We may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable We may use or disclose protected health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you while treatment is discussed.

Communications with family and others when you are not present: There may be times when it is necessary to disclose your PHI to a family member or other person involved in your treatment because there is an emergency, you are not present, or you lack the decision making capacity to agree to or object. In those instances, we will use our professional judgment, to determine if it's in your best interest to disclose your PHI. If so, we will limit the disclosure to the PHI that is directly relevant to the person's involvement with your health care.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your personal health information (PHI) for any purpose other than those identified in the previous sections without your specific, written authorization. We must obtain your *Authorization* separate from any *Consent to Use or Disclose Health Information we* may have obtained from you. If you give us authorization to use or disclose protected health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the authorization and *Consent to Use or Disclose Health Information* mentioned above) from you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your "PHI" that we use to make decisions about your treatment. You must submit a written request to in order to inspect and/or copy your health information. If you request a copy of the information a charge of $5.00/page is required for copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If law requires such a review, we will select a licensed mental health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend If you believe the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as this office keeps the information.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the protected health information "PHI" that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information for the purposes of treatment, payment and health care operations. To obtain this list, you must submit your request in writing. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request

a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend.

We are Not Required to Agree to Your Request If we do agree; we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information.

Right to Request Confidential Communications You have the right to request that we communicate with you about treatment matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication*. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Program Director or Administrator at the program.

For requests of your "PHI" including access, copying, requesting restrictions or limitations, or revocations please contact:

Anka Behavioral Health, Inc.
1850 Gateway, Blvd, Suite 900
Concord, CA 94520
925.825.4700

CHANGES TO THIS NOTICE
We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human

Services. To file a complaint with our office, contact **Vice President of Quality Improvement, (925) 825-4700**. You will not be penalized for filing a complaint.

Anka Behavioral Health, Inc.

HIPAA FORM TO BE SIGNED BY CLIENT

Evidence of receipt of the "Notice of Privacy Practices".

I, _____ (Print Name)
_____ (Program) have received the "Notice of Privacy Practices" a 7-page document that describes how information may be used and disclosed and how I can gain access to this information.

_____ _____
Person Served Signature Date

_____ _____
Witness/Signature of Person Authorized by Law Date