

**AMERICAN INDIAN HEALTH & SERVICES
NOTICE OF PRIVACY PRACTICES**

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of American Indian Health & Services (AIHS). Our "Notice of Privacy Practices" tells you how we may use and disclose your protected health information (PHI). We encourage you to read it in full. The following is a summary of the reasons we may use or disclose your information:

We may use your health information to provide you with medical treatment, and to arrange and coordinate your health care; to obtain payment for our services; and to conduct our health care operations, including quality assurance, fundraising, and general management and administration. We may disclose your health information for a variety of purposes in the public interest, as required or permitted by law. We will obtain your written authorization to use or disclose your health information for other purposes. There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as when you receive services in a substance abuse treatment agency.

We may change our "Notice of Policy Practices." If we change our notice, you may obtain a copy of the revised notice by contacting us a (805) 681-7356. If you wish to file a complaint regarding the use, disclosure or access to your PHI, you may submit a written complaint to AIHS at 4141 State Street, Ste. B-11, Santa Barbara, CA 93110 or to the U.S. Department of Health and Human Services. Filing a complaint will not affect your patient status with or care at AIHS.

I acknowledge that I have received a copy of the American Indian Health & Services' "Notice of Privacy Practices."

Signature: _____ Date: _____ Time: _____
(Patient / Legal Representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(Legal Representative)

OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's Acknowledgment, describe the good faith efforts made to obtain the individual's Acknowledgment was not obtained.

Reasons why the Acknowledgment was not obtained:

_____ Patient refused to sign this Acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

_____ Other: _____

Date: _____ Time: _____ AIHS Rep: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY

American Indian Health & Services (“AIHS”) and its employees are dedicated to maintaining the privacy of your personal health information (“PHI”), as required by applicable federal and state laws. These laws require us to provide you with this Notice of Privacy Practices, and to inform you of your rights and our obligations concerning Protected Health Information, or PHI, which is information that identifies you and that relates to your physical or mental health condition. We are required to follow the privacy practices described below while this Notice is in effect. This Notice applies to all of the records of your care generated or maintained by AIHS.

A. PERMITTED DISCLOSURES OF PHI. The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We may disclose your PHI for the following reasons:

- 1. TREATMENT.** We may disclose your PHI to a physician or other health care provider providing treatment to you. For example, we may disclose medical information about you to physicians, mental health professionals, nurses, technicians or personnel who are involved with the administration of your care. Different departments of AIHS may share medical information about you in order to coordinate different items, such as prescriptions, lab work, nutrition and behavioral health counseling.
- 2. PAYMENT.** We may disclose your PHI to bill and collect payment for the services we provide to you. For example, we may send a bill to you or to a third party payer for the rendering of services by us. The bill may contain information that identifies you, your diagnosis and procedures and supplies used. We may need to disclose this information to insurance companies to establish insurance eligibility benefits for you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.
- 3. HEALTH CARE OPERATIONS.** We may disclose your PHI in connection with our health care operations. Health care operations include quality assessment activities, reviewing the competence or qualifications of health care professionals, evaluating provider performance, and other business operations. For example, we may use and disclose medical information to contact you as a reminder that you an appointment for treatment at AIHS. We may use your PHI to evaluate the

performance of the health care services you received. We may also provide your PHI to accountants, attorneys, consultants and others to make sure we comply with the laws that govern us. We may also remove information that identifies you from a set of records so others may use it to study health care and health care delivery without learning the patient's identity.

4. **EMERGENCY TREATMENT.** We may disclose your PHI if you require emergency treatment or you are unable to communicate with us.
5. **FAMILY AND FRIENDS.** We may disclose your PHI to a family member, friend or any other person who you identify as being involved with your care or payment for care, unless you object in writing.
6. **REQUIRED BY LAW.** We may disclose your PHI for law enforcement purposes and as required by state or federal law. For example, the law may require us to report instances of abuse, neglect or domestic violence; to report certain injuries such as gunshot wounds; or to disclose PHI to assist law enforcement in locating a suspect, fugitive, material witness or missing person. We will inform you or your representative if we disclose your PHI because we believe you are a victim of abuse, neglect or domestic violence, unless we determine that informing you or your representative would place you at risk.
7. **LAWSUITS AND DISPUTES.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include a written notice to you) or to obtain an order protecting the information requested.
8. **SERIOUS THREAT TO HEALTH OR SAFETY.** We may disclose your PHI if we believe it is necessary to avoid a serious threat to the health and safety of you or the public.
9. **PUBLIC HEALTH.** We may disclose your PHI to public health or other authorities charged with preventing or controlling disease, injury or disability, or charged with collecting public health data.
10. **HEALTH OVERSIGHT ACTIVITIES.** We may disclose your PHI to a health oversight agency for activities authorized by law. These activities include audits; civil, administrative or criminal investigations or proceedings; inspections; licensure or disciplinary action; or other activities necessary for oversight of the health care system, government programs and compliance with civil rights laws.
11. **FUNDRAISING ACTIVITIES.** We may use information about you, or disclose such information to a foundation related to AIHS, to contact you in an effort to raise money for AIHS and its operations. In such cases, we would only release contact information, such as your name, address, and phone number and the dates your

received treatment or services at AIHS. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out or you may do so in writing at the address provided at the end of this Notice.

12. **RESEARCH.** We may disclose your PHI for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your PHI.
13. **WORKERS' COMPENSATION.** We may disclose your PHI to comply with laws relating to workers compensation or other similar programs.
14. **SPECIALIZED GOVERNMENT ACTIVITIES.** If you are active military or a veteran, we may disclose your PHI as required to disclose PHI to authorized federal officials for the conducting of intelligence or other national security activities.
15. **ORGAN DONATION.** If you are an organ donor, or have not indicated that you do not wish to be a donor, we may disclose your PHI to organ procurement organizations to facilitate organ, eye or tissue donation and transplantation.
16. **CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS.** We may disclose your PHI to coroners or medical examiners for the purposes of identifying a deceased person or determining the cause of death, and to funeral directors as necessary to carry out their duties.
17. **DISASTER RELIEF.** Unless you object, we may disclose your PHI to a governmental agency or private entity (such as FEMA or Red Cross) assisting with disaster relief efforts.

B. DISCLOSURES REQUIRING WRITTEN AUTHORIZATION

1. **NOT OTHERWISE PERMITTED.** In any other situation not described in Section A above, we may not disclose your PHI without your written authorization.
2. **PSYCHOTHERAPY NOTES.** Psychotherapy notes means notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities. We may disclose your psychotherapy notes as required by law.

3. **MARKETING AND SALE OF PHI.** We must receive your written authorization for any disclosure of PHI for marketing purposes or for any disclosure which is a sale of PHI.

C. YOUR RIGHTS

1. **RIGHT TO RECEIVE A PAPER COPY OF THIS NOTICE.** You have the right to receive a paper copy of this Notice upon request.
2. **RIGHT TO ACCESS PHI.** You have the right to inspect and copy your PHI for as long as we maintain your medical record. This includes medical and billing records, but may not include psychotherapy notes. You must make a written request for access to the Privacy Officer at the address listed at the end of this Notice. We may charge you a reasonable fee for the processing of your request and the copying of your medical record pursuant to the State of California. In certain circumstance we may deny your request to access your PHI, and you may request that we reconsider our denial. Depending on the reason for the denial, another licensed health care professional chosen by us may review your request and the denial.
3. **RIGHT TO REQUEST RESTRICTIONS.** You have the right to request a restriction on the use or disclosure of your PHI for the purpose of treatment, payment or health care operations, except for in the case of an emergency. You also have the right to request a restriction on the information we disclose to a family member or friend who is involved with your care or the payment of your care. However, we are not legally required to agree to such a restriction and AIHS is not required to notify other healthcare providers of these restrictions.
4. **RIGHT TO RESTRICT DISCLOSURE FOR SERVICES PAID BY YOU IN FULL.** You have the right to restrict the disclosure of your PHI to a health plan if the PHI pertains to health care services for which you paid in full directly to us.
5. **RIGHT TO REQUEST AMENDMENT.** You have the right to request that we amend your PHI if you believe it is incorrect or incomplete, for as long as we maintain your medical record. We may deny your request to amend if (a) we did not create the PHI, (b) is not information that we maintain, (c) is not information that you are permitted to inspect or copy (such as psychotherapy notes), or (d) we determine that the PHI is accurate and complete.
6. **RIGHT TO AN ACCOUNTING OF DISCLOSURES.** You have the right to request an accounting of disclosures of PHI made by us (other than those made for treatment, payment or health care operations purposes) during the 6 years prior to the date of your request. You must make a written request for an accounting, specifying the time period for the accounting, to the Privacy Officer at the address listed at the end of this Notice.
7. **RIGHT TO CONFIDENTIAL COMMUNICATIONS.** You have the right to request that we communicate with you about your PHI by certain means or at certain locations.

For example, you may specify that we call you only at your home phone number, and not at your work number. You must make a written request, specifying how and where we may contact you, to the Privacy Officer at the address listed at the end of this Notice.

8. RIGHT TO NOTICE OF BREACH. You have the right to be notified if we or one of our business associates become aware of a breach of your unsecured PHI.

D. CHANGES TO THIS NOTICE. We reserve the right to change this Notice at any time in accordance with applicable law. Prior to a substantial change to this Notice related to the uses or disclosures of your PHI, your rights or our duties, we will revise and distribute this Notice.

E. ACKNOWLEDGMENT OF RECEIPT OF NOTICE. We will ask you to sign an acknowledgement that you received this Notice.

F. QUESTIONS AND COMPLAINTS. If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to your PHI, you may complain to us by contacting the Privacy Officer at the address and phone number at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services. Please direct any of your questions or complaints to:

Privacy/Compliance Officer
American Indian Health & Services
4141 State Street, Suite B-11
Santa Barbara, CA 93110
(805) 681-7356