THE HUMAN SERVICE CENTER
Rhinelander, Wisconsin

PRIVACY PRACTICES NOTICE
Effective – 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. FEDERAL LAW REQUIRES US TO PROVIDE YOU WITH THIS NOTICE. PLEASE REVIEW IT CAREFULLY.

I. WHO WE ARE: The designation **The Human Service Center** refers to all programs provided under its legal responsibilities outlined in Wisconsin ss. 51.42, 51.437, DHS 36, 35, 75, 34. Examples include, but are not limited to, Mental Health, Alcohol and Drug Services, and Developmental Disability Programs.

II. OUR PRIVACY OBLIGATIONS: The Human Service Center must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. We must follow either federal and/or state laws, whichever is more protective of your privacy rights. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself or a provider regarding your treatment, or due to a legal requirement. If you have any questions about any part of this Notice or if you want more information about the privacy practices of The Human Service Center, please contact HIPAA Compliance Officer 705 E. Timber Dr. Rhinelander, WI 54501.

In most instances, personal health information gathered about you by The Human Service Center will be pertinent to the services you are involved in, i.e., Developmental Disability Services, Mental Health Services or Alcohol and Drug Services.

We reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy at next scheduled appointment (pertains to active clients only).

III. DISCLOSURES OF INFORMATION with client authorization: For any purposes other than the ones described below, we may only use or disclose your health information when you give us your written authorization to do so. If you sign an authorization form, you may withdraw your authorization at any time. If you wish to withdraw your authorization, please submit your written withdrawal to your case manager or counselor.

IV. DISCLOSURES OF INFORMATION: We can use or disclose your health information for the following purposes:

1. ***Treatment.*** For example, a Case Manager or Counselor within our agency may use the information in your treatment record to determine what level of treatment or case management best addresses your specific needs. The treatment selected will be documented in your treatment record, so that other health care professionals can make informed decisions about your care. If another provider requests your health information, we will request an authorization from you before providing your information.

2. ***Payment.*** For example, an insurance company, including Medical Assistance, to pay for your treatment, we must submit a bill that identifies you such as name, policy number, date of birth, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer to help receive payment for your medical bills.

3. ***Health Care Operations***. We may need your diagnosis, treatment, and outcome information to improve the quality of care we deliver and evaluate their cost effectiveness. These quality and cost improvement activities may include evaluating the performance of your health care professionals or examining the effectiveness of the treatment provided to you when compared to consumers in similar situations. If the activities require disclosure outside of our health care organization, we will request an authorization from you before disclosing that information.

   In addition, we may use your health information for appointment reminders. For example, we may look at your treatment record to determine the date and time of your next appointment with us and then send you a reminder letter to help you remember the appointment.

   Furthermore, we need to provide your health information to Clinical Supervisors who may be required to provide clinical oversight to the professionals providing you with direct service.

V. DISCLOSURES OF INFORMATION without your written authorization: The following categories describe the ways that we can use or disclose your health information:

1. ***As required or permitted by law.*** Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.

2. ***For public health activities***. We may be required to report your health information to authorities to help prevent or control disease or disability. This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect.

3. ***For health oversight activities***. We may disclose your health information to

authorities, so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.

4. ***Judicial and Administrative Proceedings.*** We may disclose your heath information in the course of an administrative or judicial proceeding in response to a court order. Under most circumstances when the request is made through a subpoena, a discovery request or involves another type of administrative order which must meet conditions for disclosure.

5. ***Law Enforcement.*** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, or missing person, or complying with a court order or other law enforcement purposes. Under some limited circumstances we will request your authorization prior to permitting disclosure.

6. ***For activities related to death****.* We may disclose your health information to coroners and medical examiners, so they can carry out their duties related to your death, such as identifying the body or determining cause of death.

7. ***For research****.* Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.

8. ***To avoid a serious threat to health or safety****.* As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.

9. ***For military or national security*****.** If you are involved with the military, national security or intelligence activities, we may release your health information to the proper authorities, so they may carry out their duties under the law.

10. ***For worker's compensation*****.** We may disclose your health information to the appropriate persons to comply with laws related to workers' compensation or other similar programs.

11. ***To those involved with your care or payment of your care****.* If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, we may release important health information about you to those people. The information released to these people may include the types of services you are receiving within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency. It is our duty to give you enough information, to allow you to decide whether or not to object to release of your health information to others involved with your care.

VI. YOUR HEALTH INFORMATION RIGHTS

You have several rights regarding your health information. If you wish to exercise any of the following rights, please contact the program administrator. Specifically, you have the right to:

1. ***Inspect and copy your health information.*** With a few exceptions, you have the right to inspect and obtain a copy of your health information after you have been formally discharged from services. You have the right to request that the copy be provided in an electronic format. Requests for access to records while actively receiving services at The Human Service Center may be denied by the program administrator/counselor/case worker under specific Wisconsin Law such as Chapter 51,61, CFS 35 governing your inspection of your mental health records. If a denial is made under this state law, you may, under certain circumstances, be able to request a formal review of such denial. Also, this right does not apply to information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information.

2. ***Request to correct your health information.*** If you believe your health information is incorrect, you may ask us to correct the information. Requests must be made in writing to HIPAA Compliance Officer 705 E. Timber Dr. Rhinelander, WI 54501 and list what you believe is an error, the date(s) of the specific information you believe is in error, the title of the document, and reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

3. ***Request restrictions on certain uses and disclosures.*** You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment, your payment or health care operation activities. You may also want to limit the health information provided to family or friends involved in your care, payment of medical bills or provided to authorities involved with disaster relief. However, we are not required to agree in all circumstances to your requested restriction.

4. ***As applicable, receive confidential communication of health information.*** You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests. To request confidential communications, you must submit your request in writing to HIPAA compliance Officer 705 E. Timber Dr. Rhinelander, WI 54501.

5. ***Receive a record of disclosures of your health information.*** In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. To request this

accounting of disclosures, you must submit your request in writing to HIPAA Compliance Officer 705 E. Timber Dr. Rhinelander, WI 54501. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list of disclosures made to you, or for purposes of treatment, payment, health care operations, national security, and certain health oversight activities.

6. ***Obtain a paper copy of this notice***. Upon your request, you may at any time receive a copy of this notice. To obtain a paper copy of this Notice, send your written request to HIPAA Compliance Officer 705 E. Timber Dr. Rhinelander, WI 54501. Additionally; this notice will be posted on our Web Site.

7. ***Notified of a Breach.*** Your provider is required by law to maintain the privacy of protected health information and provide you with notice of its legal duties and privacy practices with respect to protected health information and to notify you following a breach of unsecured protected health information that qualifies under the federal healthcare privacy rules.

VII. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact the HIPAA Compliance Officer or Program Supervisor you are receiving services in, who will provide you with the necessary assistance and paperwork.

VIII. QUESTIONS

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact your case manager or counselor, or, if they are not able to provide you the information or help you desire, The Human Service Center HIPAA Compliance Officer.

THE HUMAN SERVICE CENTER

Rhinelander, Wisconsin

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Client Name **D.O.B.**

Clinical Record Number (if applicable)

By signing this form, you acknowledge that The Human Service Center has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Initial:

[ ] **I have received The Human Service Center's Privacy Notice.**

Client's Signature Date

Witness (if required) Date

The Human Service Center staff should complete if Acknowledgement Form is not signed:

1. Does client have a copy of the Privacy Notice? Check one:
   [ ] Yes [ ] No

2. Please explain why the client was unable or refused to sign an acknowledgement form and The Human Service Center's efforts in trying to obtain the patient's signature, use the back of this page if additional space is needed for reply:

Reviewed/Revised: 4/9/03. 1/30/13, 9/4/2019, 6/23/2021