INSTITUTE FOR COMMUNITY LIVING, INC.
NOTICE OF PRIVACY PRACTICES

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.

1. Our Duty to Safeguard Your Protected Health Information

Institute for Community Living, Inc. (ICL) and its affiliate programs are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. Copies of our privacy policies and procedures are maintained in the program office. We are required by state and federal regulations to abide by the privacy practices described in this notice including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Individually identifiable information about your past, present, or future health or condition, the provisions of health care to you, or payment for the health care treatment or services you receive is considered protected health information (PHI). As such, we are required to provide you with this Privacy Notice that contains information regarding our privacy practices. This Notice explains how, when and why we may use or disclose your protected health information and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum necessary information to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will post a copy of the new/revised Privacy Notice in the main lobby and on ICL’s website. You also may request and obtain a copy of any new/revised Privacy Notice from the program office.

Should you have questions concerning our Privacy Notice, the names, addresses, telephone numbers, website addresses, etc., of whom you should contact are listed on the last page of this document.

2. How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. We have a limited right to use and/or disclose your health information for purposes of treatment, payment, or for the operations of our program. For other uses, you must give us your written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization.

Should it become necessary to release your protected health information to an outside party other than a health oversight agency, we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have included examples of the different types of uses or disclosures. These include:

A. Use and Disclosures Related to Treatment:

We may disclose your protected health information to those who are involved in providing medical treatment, rehabilitative treatment, mental health treatment, assertive community treatment or case management treatment services to you. For example we may release health information about you to agency or affiliate program physicians, dentists, nurse practitioners, nurses, psychologists, therapists, pharmacists, quality assurance personnel, students in an authorized training program, consultants, etc. We may disclose your protected health information to outside entities
or individuals performing other services relating to your treatment, such as diagnostic laboratories, home health/hospice agencies, family members, etc. Protected health information may be sent to treatment providers and agencies to which you are referred. Clinic programs that are located in school settings may disclose protected health information of persons served in those settings to teachers and administrative personnel (e.g. Principal). Protected health information may be provided to a company that transports you to and from your treatment appointments and bills Medicaid for this service. All disclosures will provide the minimum necessary information.

B. Use and Disclosures Related to Payment:
We may use or disclose your protected health information to bill and collect payment for services or treatments we provided to you. For example, we may contact your insurance company, health plan (e.g. Medicaid or Medicare), or another third party to obtain payment for services we provided to you. We will disclose protected health information to the government agencies that award entitlements (e.g. Supplemental Security Income, Medicaid) if we are providing you with assistance in getting these entitlements. We may also provide such information to a business associate to facilitate billing and collection of payments for services.

C. Use and Disclosures Related to Health Care Operations:
We may use or disclose your protected health information to perform certain functions within our program should these uses or disclosures become necessary to operate the program and to ensure that you and others we provide care and services to continue to receive quality care and services. For example, we may use a photograph of you for emergency identification purposes or use your health information to evaluate the effectiveness of the care and services you are receiving. We may disclose your protected health information to our staff (e.g. physicians, dentists, nurse practitioners, nurses, psychologists, therapists, quality assurance personnel, students in an authorized training program, case managers, counselors, staff consultants, etc.) for auditing, care planning, treatment, and learning purposes. We may also combine your health information with information from other health care providers to study how our program is performing in comparison to like programs or what we can do to improve the care and services we provide to you. When information is combined, we remove all information that would identify you so that others may use the information in developing research on the delivery of health care services without learning your identity.

D. Use and Disclosures Related to Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services:
We may use or disclose your protected health information when we contact you to remind you of an appointment or when we contact you to inform you of treatment alternatives or health-related benefits and services that may be of interest to you. For example, you may be reminded of an appointment with a psychiatrist or told of a newly released medication or procedure that has a direct relationship your treatment or medical condition.

3. Uses and Disclosures Requiring Your Written Authorization
For uses and disclosures of your protected health information other than treatment, payment and operations purposes, we are required to have your written authorization, except as permitted by law.

You have the right to revoke an authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in reliance upon your authorization. Your revocation request must be provided to us in writing. The name, address, telephone number of the person to contact is located at the end of this document. You may use our Authorization for Use or Disclosure of Protected Health Information form and/or our Revocation of an Authorization form to submit your request to us. Copies of these forms are available in the program office.

Examples of uses or disclosures that would require your written authorization include, but are not limited to, the following:

- A request to provide your protected health information to an attorney for use in a civil litigation claim;
- A request to provide certain information to an insurance or pharmaceutical program for the purposes of providing you with information relative to insurance benefits or
new medications that may be of interest to you;
• A request to provide certain information to another agency or person involved in your care; or
• A request to use your protected health information for marketing or fund raising purposes.

4. Uses or Disclosures of Information Based Upon Your Verbal Agreement

In the following situations, we may disclose a limited amount of your protected health information if we provide you with an advance oral or written notice and you do not object to such release or such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (because you were not present or you were incapacitated, etc.), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When a disclosure is made based on these or emergency situations, we will only disclose health information relevant to the person's involvement in your care. For example, if you are sent to the emergency room, we may only inform the person that you suffered an apparent heart attack, stroke, etc., and/or we may provide information on your prognosis or progress. You will be informed of, and given an opportunity to object to, further disclosures of such information as soon as you are able to do so.

We may disclose your protected health information to your family members and friends who are involved in your treatment or who help pay for your treatment. We may also disclose your protected health information to a disaster relief organization for the purposes of notifying your family and/or friends about your general condition, location, and/or status (i.e., alive or dead). You may object to the release of this information. You may use our Request to Restrict the Use or Disclosure of Protected Health Information form to notify us of your objection or your objection may be made orally. Copies of the form are available in the program office. The name, address, and telephone number of the person to whom you may make your objection is listed at the end of this document. (See also Section 6, Paragraph A below.)

5. Uses and Disclosures of Information That Do Not Require Your Consent or Authorization

State and Federal laws and regulations either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization include the following:

A. When Required by Law:

We may disclose your protected health information when a federal, state or local law requires that we report information about suspected abuse, neglect, or domestic violence, reporting adverse reactions to medications or injury from a health care product. We may disclose your protected health information to a law enforcement official:

• in response to a court order, subpoena, warrant, summons, or other similar process
• to identify or locate a suspect, fugitive, material witness or missing person
• about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement
• about a death we believe may be the result of criminal conduct
• about criminal conduct at an agency facility
• in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

B. For Public Health Activities for the Purpose of Preventing or Controlling Disease, Injury or Disability:

We may disclose your protected health information when we are required to collect information about diseases or injuries (e.g., your exposure to a disease or your risk for spreading or contracting a communicable disease or condition, product recalls, or to report vital statistics (e.g., births/deaths) to the public health authority).

C. For Health Oversight Activities:

We may disclose your protected health information to a health oversight agency such as a protection and advocacy agency, the state agency responsible for inspecting our program or to other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with
applicable state and federal laws and regulations and civil rights issues.

D. To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks:

We may disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We may also disclose your health information to a funeral director for the purposes of carrying out your wishes and/or for the funeral director to perform his/her necessary duties.

If you are an organ donor, we may disclose your protected health information to the organization that will handle your organ, eye or tissue donation for the purposes of facilitating your organ or tissue donation or transplantation.

E. For Research Purposes:

We may disclose your protected health information for research purposes only when a privacy board has approved the research project. However, we may use or disclose your protected health information to individuals preparing to conduct an approved research project in order to assist such individuals in identifying persons to be included in the research project. Researchers identifying persons to be included in the research project will be required to conduct all activities onsite. If it becomes necessary to use or disclose information about you that could be used to identify you by name, we will obtain your written authorization before permitting the researcher to use your information. Researchers will be required to sign a Confidentiality, Non-Disclosure and Information Systems Use Agreement form before being permitted access to health information for research purposes. A sample copy of this agreement may be obtained from the program’s office.

F. To Avert a Serious Threat to Health or Safety:

We may disclose your protected health information to avoid a serious threat to your health or safety or to the health or safety of others. When such disclosure is necessary, information will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.

G. For Specific Government Functions:

We may disclose protected health information of military personnel and veterans, when requested by military command authorities, to authorized federal authorities for the purposes of intelligence, counterintelligence, and other national security activities (such as protection of the President), or to correctional institutions.

6. Your Rights Regarding Your Protected Health Information

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain on our premises:

A. To Request Restrictions on Uses and Disclosures of Your Protected Health Information:

You have the right to request that we limit how we use or disclose your protected health information 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 your care or services. For example, you could request that we not disclose to family members or friends information about a medical treatment you received.

Should you wish a restriction placed on the use and disclosure of your protected health information, you must submit such request in writing. (Note: You may submit such a request using our Request to Restrict the Use and Disclosure of Protected Health Information form. Copies of this form are available in the program office.) The name, address, and telephone number of the person to whom the request is to be submitted is listed at the end of this document.

We are not required to agree to your restriction request. However, should we agree, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you; however, individuals have the right to restrict disclosures to their health plan for services for which they pay "out of pocket".
B. The Right to Inspect and Copy Your Medical and Billing Records:

You have the right to inspect and copy your health information, such as your medical and billing records that we use to make decisions about your care and services. In order to inspect and/or copy your health information, you must submit a written request to us. If you request a copy of your medical information, we may charge you a reasonable fee for the paper, labor, mailing, and/or retrieval costs involved in filing your requests. We will provide you with information concerning the cost of copying your health information prior to performing such service. The name, address, and telephone number of the person to whom you may file your request is listed at the end of this document. You may submit your requests on our Request for Inspection/Copy of Protected Health Information form. Copies of these forms are available in the program office.

We will respond within ten (10) days of receipt of such requests. Should we deny your request to inspect and/or copy your health information, we will provide you with written notice of our reasons of the denial and your rights for requesting a review of our denial. If such review is granted or is required by law, we will select a licensed health care professional not involved in the original denial process to review your request and our reasons for denial. We will abide by the reviewer’s decision concerning your inspection/copy requests. You may submit your denial review requests on our Denial of Inspection/Copy of Protected Health Information form. Copies of these forms are available in the program office.

C. The Right to Amend or Correct Your Health Information:

You have the right to request that your health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests of us for as long as we maintain/retain your health information. Your requests must be submitted to us in writing. We will respond within sixty (60) days of receiving the written request. If we approve your request, we will make such amendments/corrections and notify those with a need to know of such amendments/corrections.

We may deny your request if:

- Your request is not submitted in writing
- Your written request does not contain a reason to support your request
- The information was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- It is not a part of the health information kept by or for our program
- It is not part of the information which you would be permitted to inspect and copy; and/or
- The information is already accurate and complete.

If your request is denied, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response you may have relative to the information and denial process appended to your health information.

The name, address, and telephone number of the person to whom you may file your request is listed at the end of this document. You may submit your amendment/correction requests on our Request for Amendment/Correction of Protected Health Information form. Copies of these forms are available in the program office.

D. The Right to Request Confidential Communications:

You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you may request that we not send any health information about you to a family member’s address. We will agree to your request as long as it is reasonably easy for us to do so. You are not required to reveal nor will we ask the reason for your request.

To request confidential communications you must:

- Notify us in writing;
- Indicate what information you wish to limit;
- Indicate whether or not you wish to limit or restrict our use or disclosure of such information; and
• Identify to whom the restrictions apply (e.g., which family member(s), agency, etc).

The name, address, and telephone number of the person to whom you may file your request is listed at the end of this document. You may submit your requests on our Request for Restriction of Confidential Communications form. Copies of these forms are available in the program office.

E. The Right to Request an Accounting of Disclosures of Protected Health Information:

You have the right to request that we provide you with a listing of when, to whom, for what purpose, and what content of your protected health information we have released over a specified period of time. This accounting will not include any information we have made for the purposes of treatment, payment, or health care operations or information released to you, your family, or disclosures made for national security purposes, or any releases pursuant to your authorization.

Your request must be submitted to us in writing and must indicate the time period for which you wish the information (e.g., May 1, 2003 through August 31, 2005). Your request may not include releases for more than six (6) years prior to the date of your request and may not include releases prior to April 14, 2003. Your request must indicate in what form (e.g., printed copy or email) you wish to receive this information. We will respond to your request with sixty (60) days of the receipt of your written request. Should additional time be needed to reply, you will be notified of such extension. However, in no case will such extension exceed thirty (30) days. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period. 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.

The name, address, and telephone number of the person to whom you may file your request is listed at the end of this document. You may submit your requests on our Request for an Accounting of Disclosures of Protected Health Information form. Copies of these forms are available in the program office.

F. The Right to Receive a Paper Copy of This Notice:

You have the right to receive a paper copy of this notice even if you have agreed to receive an electronic copy of this notice. You may request a paper copy of this notice at anytime or you may obtain a copy of this information from ICL’s website.

7. How to File a Complaint about Our Privacy Practices

If you have reason to believe that we have violated your privacy rights, violated our privacy policies and procedures, or you disagree with a decision we made concerning access to your protected health information, etc., you have the right to file a complaint with us or the Secretary of the Department of Health and Human Services. Complaints may be filed without fear of retaliation in any form.

The name, address, and telephone number of the person to whom you may file your complaint is listed below. You may submit your complaint on the program’s Grievance/Complaint Resolution form. Copies of these forms are available in the program office.

8. Persons to Contact to Follow Up on Privacy Related Issues

You may contact the individuals listed on the next page to follow up on any issues related to the privacy of your protected health information.

9. Other Permitted and Required Uses and Disclosures

Other disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. (It should be noted that the Institute for Community Living (ICL) does not engage in the sale of protected health information and the use of
such information for paid marketing, the disclosure of genetic information for underwriting purposes and does not fundraise using this information. All other uses and disclosures not described in the Notice of Privacy Practices will be made only with your authorization.

10. You have the right to receive notice of a breach

We will notify you if your unsecured protected health information has been breached.

Persons to Contact to Follow Up on Privacy Related Issues

A. The privacy contact person in this program is:

B. The ICL Privacy Officer is:
Aimee Gerst
40 Rector Street – 8th Floor
New York, New York 10006
Tel: (212) 385-3030, ext. 12005
Fax: (917) 831-4442
E-mail: agerst@iclinc.net

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