NOTICE OF PRIVACY PRACTICES

Effective date of notice: 6/28/2018

WHEN IT COMES TO YOUR HEALTH INFORMATION, YOU HAVE CERTAIN RIGHTS. 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.

CHOICES VOLUNTARILY COMPLIES WITH THE FEDERAL HEALTH INSURANCE PORTABILITY ACT (HIPAA). WE RESERVE THE RIGHT TO MODIFY OUR PRIVACY PRACTICES AND THIS NOTICE AT ANY TIME, AND THE CHANGES WILL APPLY TO ALL INFORMATION WE HAVE ABOUT YOU. A COPY OF THIS AND ANY FUTURE VERSION OF THIS NOTICE WILL BE AVAILABLE UPON REQUEST. CHOICES WILL TAKE REASONABLE STEPS TO MINIMIZE THE USE, DISCLOSURE OF, AND REQUESTS FOR PHI TO THE MINIMUM NECESSARY TO ACCOMPLISH THE INTENDED PURPOSES.

Your Rights

This section explains your rights and some of our responsibilities to help you. You have the right to:

Get an electronic or paper copy of your medical record:
- Unless your access is restricted for clear and documented treatment reasons, you can ask to see or get a paper copy of your medical record and other health information we have about you. Ask us how to do this.

Ask us to correct your medical record:
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will provide verbal explanation.

Request confidential communications:
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:
- You can ask us not to use or share certain health information for treatment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. We cannot agree to limit uses/disclosures that are required by law.

Know with whom we have shared information:
- Your records will indicate any time we have shared your health information, who we shared it with, and why.

Choose someone to act for you:
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:
- You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue SW, Washington, D.C. 20201 / calling: 1-877-696-6775 / or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share: If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief or emergency
- *If you are not able to tell us your preference (for example if you are unconscious), we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

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Our Uses and Disclosures

We are allowed or required to share your information in several ways: to benefit you and in ways that contribute to the public good, such as public health and research and situations listed below. We must meet many conditions in the law before we can share your information for these purposes.
For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

We use or share your health information in the following ways:

To treat you: We use your health information and share it with other professionals who are treating you.
To run our organization: We use and share your health information to run our practice, improve your care, and contact you when necessary.
To help with public health and safety issues – we can share health information about you for certain situations:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

For research: We can use or share your information for health research.
Complying with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
Addressing workers' compensation, law enforcement/reporting agencies, and other government requests:

- For workers' compensation claims
- For law enforcement purposes, with a law enforcement official, or with other reporting/enforcement agencies (such as the Department of Social Service)
- With health oversight agencies for activities authorized by law (such as mandatory reporting of positive STI results to the Colorado Department of Public Health and Environment)
- For special government functions (such as military, national security, and presidential protective services)

Responding to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We voluntarily submit to maintain the privacy and security of your protected health information (PHI).
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We will not use or share your information other than as described here unless you tell us we can and your request is documented in writing. If you tell us we can, you may change your mind at any time and should let us know.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This notice is provided to all clients. You may receive a paper or electronic copy of this notice or any future versions of this notice upon request at any time.

The undersigned certifies that he/she has read the information on this form, is the client or the client's personal representative, and received a copy of this form (or declined a copy by initialing below).

____
Printed Name of Client

____ ____________________
Signature of Client **Date**

____ ____________________
Witness Signature (Staff/Volunteer) **Date**

____ ____
Printed Name of Client's Personal Representative **Signature of Personal Representative**
(if client unable to sign for self)

Copy given to client on: ___ / ___ /_______ Witness initials: _______ -**OR**- Copy declined by client on: ___ / ___ /_______ Client initials: _______