Notice of Privacy Practices

DCF-2236
04/03 (New)

This notice describes how your medical information may be used and disclosed and how you can get access to this information.

Please review this notice carefully.

The Department of Children and Families (DCF) is federally mandated to maintain the privacy of your health information and wants you to know about DCF practices for protecting your health information. DCF is required to follow the terms of this notice. The information DCF maintains may come from any of the providers you see while you are a client of DCF. The information DCF records and maintains is known as Protected Health Information, or PHI. DCF will not use or disclose your PHI without your authorization, except as described in this notice.

DCF reserves the right to change our practices and to make the new provisions effective for all Protected Health Information maintained. Should DCF information practices change, DCF will amend the notice and make the notice available upon request or after the new effective date of the notice. This notice is effective as of April 14, 2003.

Definitions

Individual refers to the person who is the subject of the protected health information.

Protected Health Information means individually identifiable information maintained or transmitted in any form.

Authorization is the permission granted by the patient or the patient's guardian to use or disclose protected health information for purposes other than health care operations; e.g., HIV testing or substance abuse screening.

Treatment is the provision, coordination, or management of health care and related services by one or more health care providers.

Payment consists of the activities undertaken by either a health plan or health care provider to obtain or provide reimbursement for the provision of health care.

Health Care Operations consist of the administrative, financial, and legal activities that support the essential health care functions of treatment and payment.

Uses and Disclosures

Your PHI is primarily used for:

- Treatment - shared with another doctor for that treatment
- Payment; e.g., to a pharmacy for medication
- Health Care Operations – DCF internal quality efforts
- Reminders to you of appointments for treatment or treatment plan conferences or to provide information of interest to you about your treatment or health.

Permitted disclosures of your PHI, without your authorization, may include the following:

- Abuse or Neglect and associated judicial proceedings
- Medical Research
- Law Enforcement
- Adjudicated Youth
- Public Health
- Notification of a family member or guardian of where you are and your condition.

What are your rights?

You (your parent or guardian) have the right to:

- Request restrictions in writing on certain uses and disclosures of protected health information. DCF reserves the right to deny the restrictions.
- Receive confidential communications of PHI by an alternative method; e.g., email notification.
- Inspect and copy your health record by written request only.
- Request amendment to your PHI.
- Receive an accounting of DCF disclosures of your PHI.
- Receive a paper copy of this notice upon request.
- Revoke, in writing, an authorization at any time.

How can you report a problem?

If you feel your privacy rights have been violated, you may file a complaint in writing with the DCF Privacy Office, 505 Hudson Street, Hartford, CT 06106 or with the Secretary of the Department of Health and Human Services (DHHS). There will be no retaliation for filing a complaint.

Would you like more information?

If you have questions and would like more information, you may contact the ***DCF Privacy Office at 1-866-360-1734***.

I understand that my records are protected under the federal regulations contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

I also understand that I may restrict or prohibit certain uses and disclosures at any time, except to the extent that action has been taken in reliance on previously released information.

Signature of client/patient: _____ **Date:** _____
(or authorized representative when required)

Signature of DCF worker: _____ **Date:** _____
(confirmation that client received copy of notice)