Department of Behavioral Health
TRANSMITTAL LETTER

SUBJECT **Updated DBH HIPAA Privacy Forms 1 and 3:** DBH-HIPAA Form 1, Joint Notice of Privacy Practices DBH HIPAA Form 3, Authorization to Use or Disclose PHI, including mental health information and alcohol/drug treatment and prevention information		
POLICY NUMBER **DBH 1000.3, Privacy Policies and Procedures Manual**	**DATE** **JUL 1 3 2016**	**TL# 299**

Purpose. To transmit updated HIPAA Privacy Forms 1 and 3 to be used by the Department of Behavioral Health (DBH), effective immediately. The provisions in these forms shall take precedence over any corresponding provisions in the DBH 1000.3, Privacy Policies and Procedures Manual until the manual is updated in its entirety.

This revision shall only apply to DBH-HIPAA Form 1, Joint Notice of Privacy Practices, and DBH-HIPAA Form 3, Authorization to Use or Disclose PHI, including mental health information and alcohol/drug treatment and prevention information. This is **not** a revision of the entire DBH 1000.3, Privacy Policies and Procedures Manual.

Applicability. This policy applies to DBH and DBH-contracted providers with a Human Care Agreement, the Behavioral Health Authority, Psychiatric Residential Treatment Facilities, and contracted hospitals.

Policy Clearance. Reviewed by affected, responsible staff, and cleared through the appropriate Behavioral Health Authority offices, including DBH's General Counsel and Privacy Officer.

Effective Date. This policy is effective immediately.

Superseded Forms. This policy forms replaces the DBH Policy 1000.3 Privacy Policies and Procedures Manual forms listed below:

DBH-HIPAA Form 1, Joint Notice of Privacy Practices, 10/01/2013

DBH-HIPAA Form 3, Authorization to Use or Disclose PHI (including mental health information and alcohol/drug treatment and prevention information), 10/01/2013

1. DBH Network providers are obligated to protect the privacy of a consumer's/client's Protected Health Information (PHI). During intake or the first service encounter with a consumer/client, Network providers shall give consumers/clients a written notice that describes how they may use or disclose PHI (DBH-HIPAA Form 1, Joint Notice of Privacy Practices).

2. DBH Network providers shall request that the consumer/client signs the acknowledgment of receipt of the Notice of Privacy Practices (last page of Form 1). If consumers/clients refuse to sign the

acknowledgment of receipt, the provider shall document the refusal on the receipt. The provider must file the original acknowledgment of receipt in the consumers/clients clinical record.

3. DBH-HIPAA Form 3, Authorization to Use or Disclose PHI (including mental health information and alcohol/drug treatment and prevention information) is required for any release of information, except for disclosures that do not require authorization pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended; District of Columbia Mental Health Information Act of 1978, as amended; or 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, as applicable.

4. Disclosure of information by a certified alcohol/drug treatment and prevention provider that identifies an individual, directly or indirectly, as having a current or past drug or alcohol problem or participating in a drug/alcohol treatment and prevention program is prohibited (including to other providers within the Network) unless the individual consents in writing or other exceptions in 42 CFR Part 2 apply.

Questions may be directed to the DBH Privacy Officer, Sabriana Clark, at (202) 671-4088.

Implementation Plans. Providers should designate specific staff to carry out implementation and training as needed and program managers are responsible for following through to ensure compliance.

Distribution. This policy forms will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.

7/13/2016

Tanya A. Royster, M.D. **Date**
Director, DBH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION INCLUDING MENTAL HEALTH INFORMATION AND ALCOHOL/DRUG TREATMENT AND PREVENTION INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Department of Behavioral Health (DBH) Network includes DBH and DBH-certified or licensed providers that have entered into a contract or agreement with DBH to provide mental health services or supports and or alcohol/drug treatment and prevention services. This notice explains how participants in the DBH Network will use, share and protect your Protected Health Information (PHI).

What is PHI?
PHI is any written, recorded, or oral information which identifies you or could be used to identify you and relates to your behavioral health, including your care and payment for your care.

USES AND DISCLOSURES OF YOUR PHI WHEN AUTHORIZATION IS NOT REQUIRED

Under what circumstances can my PHI be shared without my consent or authorization?

(1) **Your PHI (including mental health information, and alcohol/drug treatment and prevention information maintained by an alcohol/drug treatment and prevention provider) may be disclosed without your prior consent or authorization in the following situations:**

- To report suspected child abuse or neglect;
- In a medical emergency when there is a threat to health of individual that requires immediate medical attention.
- For health oversight activities such as evaluating programs and audits.
- In response to a court order and subpoena.
- For research purposes, such as research related to the development of better treatments, provided the research study meets certain privacy requirements.
- To report a crime or a threat of crime occurring on the provider's premises or directed against the provider's staff.
- Pursuant to a qualified service organization or business associate agreement.

(2) **For Mental Health Information Only**. In addition, mental health PHI may be disclosed without prior consent or authorization under the following circumstances:

- When DBH Network providers or the District's health and human services agencies and their respective service providers covered under HIPAA, including Department of Human Services, Child and Family Services Agency, Department of Health, and Department of Health Care Finance, need to coordinate treatment, benefits and services.
- When health care and mental health care providers outside of the DBH Network need to coordinate treatment, benefits and services; however, this authority is not absolute. You may opt-out of granting the provider the right to share your PHI and providers cannot disclose progress notes. "Opt-out" means that you do not want your provider to share your PHI with providers outside of the DBH

network unless you have signed a release authorizing disclosure or the provider is legally obligated to share your PHI. For example, a provider may be legally obligated to share your PHI during a medical emergency or in response to a court order.

- When a mental health professional believes it is necessary to ask for emergency psychiatric hospitalization, or to protect you or someone else from serious physical harm.
- To report suspected adult or child abuse or neglect.
- When requested by a designated agency representative for the District of Columbia protection and advocacy agency when investigating allegations of abuse or neglect for persons with mental illness;
- To correctional institutions or law enforcement officials having lawful custody of you in order to facilitate the delivery of mental health services and supports.
- To monitor your compliance with a condition of pretrial release, probation, parole, supervised release, or diversion agreement regarding mental health treatment.

FREQUENTLY ASKED QUESTIONS

If I am in an alcohol/drug treatment and prevention program, can the provider share my alcohol/drug treatment and prevention information with another Network provider without my consent?

No. 42 CFR Part 2 specifically requires written consent to disclose alcohol/drug treatment and prevention information unless an exception noted in (1) above applies.

Can my PHI be used or disclosed for other purposes if I give permission?

Yes. Your PHI can be shared for purposes other than those described above, but only if you give specific permission by signing an authorization form. For example, you might give us permission to release your PHI to a provider outside of the Network to allow that provider to give you a service or treatment that you need. You have the option of saying that the authorization will remain in effect for any period of time up to three hundred sixty-five (365) days, except in cases where you authorized the disclosure in order to obtain life insurance or non-cancellable or guaranteed renewable health insurance, in which case the authorization can be up to two (2) years from the date of the policy.

If I authorize disclosure, can I revoke my authorization?

Yes. Except for insurance purposes, you can revoke your authorization anytime by giving written notice to your provider. But you must do this in writing and bring it to your provider so that Network providers will stop using and disclosing your PHI. Network providers are permitted to use and disclose your PHI based on your authorization until the Network provider receives your revocation in writing. The revocation of your authorization will not affect any action by the Network provider before it was received.

What is the Network required to do to protect my PHI?

All Network providers are required by law to protect the privacy of your PHI, and to provide you with this Notice of their legal duties and privacy practices. If the law requires changes to the terms of this Notice, all Network providers will be required to follow the terms of the changed Notice.

What rights do I have concerning my PHI?

- You have the right to opt out of disclosing your mental health PHI to health care providers that are not members of the DBH Network.
- You have the right to see and copy your PHI with limited exceptions.
- You have the right to request that your record of PHI be amended.
- You have the right to be informed about your PHI in a confidential manner that you choose. The manner you choose must be reasonable for us to do.

- You have the right to request that we limit certain uses and disclosures of your PHI. Network providers do not have to agree to your restrictions, but if we do agree, we must follow the restrictions.
- You have a right to restrict disclosure of PHI when paid out of pocket.
- You have the right to obtain information about disclosures that the Network providers have made of your PHI.
- You have the right to have a paper copy of this Privacy Notice.
- You have a right to be notified of a breach of your PHI.

What can I do if I wish to exercise my rights, have questions, or want to complain about the use and disclosure of my PHI?

If you wish to exercise your rights, or you have a question or complaint about the use and disclosure of your PHI, **you should contact the Privacy Officer at the agency providing you treatment**. You may also contact the DBH Privacy Officer listed below:

DBH Privacy Officer
D.C. Department of Behavioral Health
64 New York Avenue, NE, 2nd Floor
Washington, D.C. 20002
Phone: (202) 671-4088
TTY/TTD: (202) 673-7500
E-mail: dbh.privacy@dc.gov

You may also contact the U.S. Department of Health and Human Services, Office of Civil Rights, at the following address:

Office for Civil Rights – Region III
U.S. Department of Health and Human Services
150 S. Independence Mall West, Suite 372,
Public Ledger Building
Philadelphia, PA 19106-9111
Main Line (215) 861-4441; Hotline (800) 368-1019;
Fax (215) 861-4431; TDD (215) 861-4440
E-mail: ocrmail@hhs.gov

In addition, you have the right to file a grievance through the DBH grievance procedures. No one may take any action against you for complaining about the use and disclosure of your PHI.

If you have a hard time understanding this Notice, please ask for assistance.

CHANGES TO THIS NOTICE

If the law requires changes to the terms of this Notice, all Network providers will be required to follow the terms of the changed Notice. If the notice is changed, the changes will apply to all PHI (including mental health information, and alcohol/drug treatment and prevention information maintained by an alcohol/drug treatment and prevention provider) created or received before the notice was changed. The amended notice will be posted on the DBH website, and should be provided to you at your next visit and posted at all service sites.

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the DBH Provider Network's Joint Notice of Privacy Practices, and I have been offered a copy of the Notice.

Signature _____ Date _____

Please Print Name _____

Relationship (if other than consumer/client) _____

_____ I refuse to sign this form.

_____ I opt-out of sharing my PHI with my health care and mental health care providers outside of the DBH Network. I understand that opting-out does not affect my DBH provider's authority to disclose my mental health information without a release under the D.C. Mental Health Information Act under the circumstances described in Section (2) of the Joint Notice of Privacy Practices.

Note to Network Personnel:

If consumer/representative refuses the Notice or to provide a signature, acknowledge refusal by providing the following information:

Network Personnel's Name: _____

Title: _____

Signature: _____ Date _____

Comments: _____

_____

_____

Joint Notice of Privacy Practices & copy of Acknowledgement Form – Consumer/Client
Original Acknowledgement Form – Clinical Record

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Authorization to Use or Disclose Protected Health Information
(including mental health information and alcohol/drug treatment and prevention information)

Name of Consumer/Client (print) **Identification Number**

Address **Date of Birth**

City/State/Zip Code **Other Name(s) Used**

RELEASE INFORMATION TO:	**INFORMATION TO BE RELEASED BY:**
Name/Title: _____	Name/Title: _____
Organization: _____	Organization: _____
Address: _____	Address: _____
Phone #: _____ Fax # _____	Phone # _____ Fax # _____

INFORMATION TO BE DISCLOSED: **I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of my clinical records. This includes specific permission to release all records and other information regarding my treatment, hospitalization, and outpatient care including:** *(The following items must be checked in order to be released)*

- ☐ Drug abuse, alcoholism or other substance abuse;
- ☐ Records which may indicate the presence of a communicable or non-communicable disease, and tests for records of HIV/AIDS.

Limitations for Release:

- ☐ Only for dates of service from _____ to _____
- ☐ Exclusions (must list if there are any exclusions) _____
- ☐ Only the following: (must list specific documents if applicable) _____

INFORMATION TO BE USED FOR THE FOLLOWING PURPOSE(S) ***(List):*** _____

_____

EXPIRATION: This authorization will expire in three hundred and sixty-five (365) days from the date this form was signed unless one of the following is checked, in which case it will expire on the earliest date:

- ☐ On _____ (cannot be more than three hundred and sixty-five (365) days from the date of this form).
- ☐ On _____ when: _____ occurs.
  (Date Required) *(Identify Specific Event)*

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice to the organization that was authorized to release this information. I understand that revocation of this authorization will *not* affect any action by the organization that was authorized to release this information before it received my written notice of revocation. I understand that my right to revoke this authorization may be limited if the purpose of this authorization involves applying for health or life insurance.

OTHER RIGHTS: I understand that this information cannot legally be redisclosed by the person or organization that received it without my authorization, except as allowed by law. I understand that I have the right to inspect my record of protected health information. I also understand that I cannot be denied enrollment or services if I decide not to sign this form. However, I may not be able to apply for benefits or renewal of benefits that would help pay for these services.

SIGNATURE OF CONSUMER/CLIENT OR PERSONAL REPRESENTATIVE:

I, _____, understand that, by signing this form, I am authorizing the use and/or disclosure of the protected health information identified above.

Full Name (Print) _____

Signature _____ Date _____

AUTHORITY TO ACT ON BEHALF OF CONSUMER/CLIENT (check one):

Self _____ Parent _____ *Personal Representative _____ (includes legal guardian and power of attorney)
Other _____ (must specify): _____

Address: _____ Phone # _____

Supporting documentation required for a personal representative. Attach copy to this form.

SIGNATURE OF MINOR: If the consumer/client is at least fourteen (14) years old, but under eighteen (18) years old, this authorization is not valid unless the consumer/client signs in addition to the parent, legal guardian or other personal representative. A minor of any age may authorize disclosure based on his or her signature alone, if (1) he or she is an emancipated minor, or (2) he or she is receiving treatment or services without a parent or legal guardian giving consent.

Full Name (Print) _____ DOB _____ Phone # _____

Address: _____

Signature of Minor _____ Date _____

VERIFICATION OF IDENTITY OF CONSUMER/CLIENT OR PERSONAL REPRESENTATIVE PROVIDING CONSENT IS REQUIRED

- ☐ Personal identification (government issued photo ID): Attach a copy.
- ☐ Government official or Department of Behavioral Health provider's oral representation.

_____

_____

State what you were told and why your reliance on it was reasonable under the circumstances.

If form is mailed in, the signature on the form must be notarized or the person who is providing consent must have his or her signature notarized or attach a copy of his or her government issued ID.

I Verified the Identity of the Person Providing Consent

Full Name (Print) _____ Title _____

Signature _____ Date _____

I Revoke this Authorization Effective: _____ **Signature** _____
(Date) *(Consumer/Client, or personal representative and his or her relationship to the consumer/client)*

TO THE RECORDS CUSTODIAN:

1. Provide a copy of this authorization to the consumer/client or personal representative.
2. Put signed original in the consumer's clinical record.
3. Log this authorization or forward to the Privacy Officer or designee for logging.
4. Send a copy of this form with the information to be disclosed.