JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE DEPARTMENT OF BEHAVIORAL HEALTH MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI), AND HOW YOU CAN ACCESS YOUR PHI. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Department of Behavioral Health (DBH) and its certified providers must maintain the confidentiality of your medical, mental and substance use disorder treatment information, also known as Protected Health Information (PHI).

Your PHI is any record that can identify you and relates to your health care. Your PHI can include records such as your name, address, birth date, phone number, social security number, Medicaid or Medicare number, health insurance policy information and information about your health condition or care.

1. OUR DUTY TO PROTECT YOUR PHI

The law requires that DBH and its certified providers maintain the privacy of your PHI. We must provide you with this Notice of our legal duties and privacy practices, which explains how your PHI will be used, shared and protected. The law requires that DBH and its certified providers adhere to this Notice.

2. USE OF YOUR PHI

We may use your PHI for treatment, payment and other permitted purposes. We allow DBH personnel to process payment for your medical, mental health and substance use treatment with your PHI. Additionally, we allow DBH personnel access to your PHI as needed for reviewing the quality of care you receive, reviewing provider certification and licensure and conducting audits.

We may also use and/or disclose your PHI without your permission when permitted by law. Please note that different sets of laws govern the confidentiality of your substance use treatment records and your medical/mental health records. Information about how your records can be shared is detailed below.

We may disclose your **medical and mental health PHI** without your permission:

1. With other healthcare providers or District Health and Human Services Agencies and their contractors (including the Department of Human Services, the Child and Family Services Agency, DC Health and the Department of Health Care Finance) to coordinate your treatment, benefits and services. You may opt-out of granting DBH the right to share your PHI with providers **outside** of the DBH network and the District Health and Human Services cluster. “Opt-out” means that you do not want your provider to share your PHI with outside providers unless you have signed a release authorizing disclosure or we are legally obligated to share your PHI (*i.e.* DBH may be legally obligated to share your PHI during a medical emergency or in response to a court order).
2. To submit claims for services delivered to you.
3. For public health activities such as reporting suspected child abuse or neglect or to prevent or control disease.

4. If DBH or its certified providers reasonably believe that you are the victim of abuse, neglect, or domestic violence, we may share your PHI with a social services or law enforcement agency.
5. For oversight activities like audits; investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions.
6. In response to an order of a court or administrative tribunal, or a subpoena.
7. To law enforcement officials in response to a warrant, subpoena or an administrative request; to identify or locate a suspect, fugitive, witness, or missing person; or to report actual or threatened criminal conduct, including those occurring on the premises of DBH or a certified provider.
8. In a medical or psychiatric emergency when your health requires immediate medical attention.
9. For research purposes if the research study meets certain privacy requirements.
10. To prevent a serious or imminent threat to public health and safety.
11. When requested by a representative from a Protection and Advocacy Agency for the District of Columbia as part of an investigating into alleged abuse or neglect of a person with mental illness.
12. To correctional institutions having lawful custody of you to coordinate your treatment or care, and when needed to ensure the health and safety of other inmates and staff.
13. To monitor your compliance with a condition of pretrial release, probation, parole, supervised release, or diversion agreement regarding mental health treatment.
14. Pursuant to a qualified service organization or business associate agreement.

In addition, we may disclose your **substance use treatment PHI** without your permission **only**:

1. In medical emergencies when we cannot obtain your written consent.
2. For research purposes, if the research study meets certain privacy requirements.
3. For audits and evaluations of the substance use treatment program.
4. With a valid court order.
5. To report suspected child abuse and neglect.
6. To law enforcement to report a crime that occurred on the premises of a substance use provider.
7. To a qualified services organization to provide services to the substance use treatment program.

You may choose to share your PHI with a specific person, business or organization for purposes other than those described above (for instance, you may want to share your PHI with your attorney). If you would like to do so, you must sign a Release of Information to allow DBH to share your PHI.

3. PARTICIPATION IN THE DISTRICT OF COLUMBIA HEALTH INFORMATION EXCHANGE

We have chosen to participate in CRISP DC, a regional health information exchange (HIE) serving the District of Columbia. CRISP DC is also affiliated with and shares data with other HIEs, including those in Alaska, Connecticut, Maryland, and West Virginia. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. Unauthorized disclosures of mental health information are prohibited pursuant to the District of Columbia Mental Health Information Act of 1978 (§§7-1201.01 to 7-1207.02). Part 2 of Title 42 of the Code of Federal Regulations (42 C.F.R. Part 2) prohibits unauthorized disclosure of substance use disorder patient records.

If you are receiving **mental health treatment services**, you will be registered in CRISP DC unless you **opt-out** of participating. If you do not want your information shared in this way, you may "opt-out" and disable access to your health information available through CRISP DC by calling 1-877-952-7477 or completing and submitting an opt-out form through the CRISP DC website at www.crisphealth.org. The opt-out will not affect any action by CRISP DC before it was received. CRISP DC will comply with opt out requests to the extent

required by applicable federal and D.C. privacy laws. Certain reporting required by law, such as public health reporting and Controlled Dangerous Substances information, will still be available to providers even if you opt-out.

If you are receiving **substance use treatment services**, you may also **consent to share** substance use treatment services through the CRISP DC HIE with your treating providers. Substance Use Disorder (SUD) data may be protected by additional regulations that require explicit consent to share SUD data through the HIE. Please ask your provider's staff to assist you in completing the Patient Consent to Disclose SUD Treatment Information form. This consent may be revoked at any time.

4. AUTHORIZATION FOR OTHER USES AND DISCLOSURES OF PHI NOT MENTIONED IN THIS NOTICE

DBH and its certified providers will only use or disclose your PHI for purposes addressed by this Notice. DBH and its certified providers will never sell your PHI and will obtain your written authorization for other uses and disclosures. You may revoke your authorization in writing at any time. The revocation of your authorization will not affect any action taken by DBH or its certified providers before the written revocation was received. You may contact the DBH Privacy Officer at the address listed at the end of this Notice for further information.

5. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI. In writing, you may:

1. Ask us to limit how your PHI is used or given out, including the right to opt-out of disclosures of your mental health information to providers outside of the DBH provider network and the District Health and Human Services cluster. We are not required to agree to your request. If we do agree, we will honor it;
2. 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;
3. Generally, see and copy your PHI. You may ask that any refusal to do so be reviewed. You may be charged a reasonable fee for copies;
4. Ask DBH or a provider to change PHI in your record. We may not make your requested changes. If so, we will tell you why we cannot change your PHI. You may respond in writing to any denial. You may ask that both our denial and your response be added to your PHI;
5. Get a listing of certain entities that received your PHI from DBH after April 14, 2003. This list will not include a listing of disclosures made for treatment, payment, healthcare operations, information you authorized us to provide, or government functions;
6. Restrict disclosure of PHI when paid out of pocket;
7. Request a paper copy of this Notice of Privacy Practices; and
8. Be notified of a breach of your 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:

DBH Privacy Officer
Department of Behavioral Health
64 New York Avenue, NE, 3rd Floor
Washington, D.C. 20002
(202) 671-4088
TTY/TTD: (202) 673-7500
E-mail: dbh.privacy@dc.gov

You may also complain to the U.S. Department of Health and Human Services, by sending a written complaint to the following address:

Office for Civil Rights – Region III
U.S. Department of Health and Human Services
Centralized Case Management Operations
U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
Hotline (800) 368-1019

Please check https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html for more information on making a complaint to DHHS.

If you have access to a computer, you may submit a complaint form electronically using the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by e-mail: OCRComplaint@hhs.gov

You always have the right to file a grievance through the DBH grievance procedures. Please refer to DBH Policy 515.3, Consumer Rights for further information about how to file a grievance. Please note that 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.

Acknowledgement of Receipt
of the Notice of Privacy Practices

We participate in the CRISP DC health information exchange to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP DC medical record sharing policies at www.crispdc.org.

If you are being treated for SUD by our facility, your data will not be shared through CRISP DC unless you file a consent to specifically share this information. If you elect to consent, your SUD information will be shared with other clinicians who treat you, for payment of services, and other operational purposes like quality improvement and care coordination. Right now, to share your information, your consent must allow for the sharing of your information for all purposes related to treatment, payment, and operations. You can ask your clinician for more information about how to consent, what that consent means and how you can revoke your consent.

I acknowledge that I have been offered a copy of the DBH's Joint Notice of Privacy Practices.

Signature____ Date ____________________________

Please Print Name____

Relationship if Other than Consumer/Client____

________ I refuse to sign this form.

Note to Certified Provider:

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

Certified Provider Personnel's Name and Title:

____

Signature____ Date ____________________________

Comments:

____

____

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