

**Department of Mental Health
TRANSMITTAL LETTER**

SUBJECT		
Revised DMH Privacy Forms: DMH-HIPAA Form 1, Joint Notice of Privacy Practices (06/01/2012) DMH HIPAA Form 2, Joint Consent Form (06/01/2012) DMH HIPAA Form 3, Authorization to Use or Disclose PHI, including Mental Health Information (06/01/2012)		
POLICY NUMBER DMH 1000.3, DMH Privacy Policies and Procedures Manual	DATE JUN 06 2012	TL# 168

Purpose. To transmit three (3) revised DMH privacy forms that were generally updated to better comply with federal laws and regulations and District policy.

Applicability. DMH and its participating Network providers.

- *DMH Network* means an organized health care arrangement consisting of DMH and participating providers (Network providers).
- *Participating Provider* means a mental health provider that, through participating in the joint consent process for authorization promulgated by DMH, joins the organized health care arrangement created by DMH to use or disclose protected health information (PHI) in carrying out the provision of mental health services or mental health supports.

EFFECTIVE IMMEDIATELY:

DMH and its participating Network providers shall use the following revised DMH privacy forms as outlined below:

- DMH-HIPAA Form 1, Joint Notice of Privacy Practices (06/01/2012)
- DMH-HIPAA Form 2, Joint Consent Form (06/01/2012)
- DMH-HIPAA Form 3, Authorization to Use or Disclose PHI, including Mental Health Information (06/01/2012).

1. DMH Network providers are obligated to protect the privacy of a consumer’s PHI. Network providers must give consumers written notice of the uses and disclosures of PHI within the Network (DMH-HIPAA Form 1, Joint Notice of Privacy Practices) during intake.
2. Network providers must then ask the consumer to sign DMH-HIPAA Form 2, Joint Consent Form, to authorize use and disclosure of PHI to participants in the Network.
3. If the consumer does not sign the DMH-HIPAA Form 2, Joint Consent Form, disclosures within the Network may not be made without a HIPAA/MHIA written authorization signed by the consumer or the consumer’s personal representative (e.g., DMH-HIPAA Form 3, Authorization to Use or Disclose PHI, including Mental Health Information).
4. DMH-HIPAA Form 3 is also required for any other release of information, except for disclosures that do not require authorization pursuant to District of Columbia Mental Health Information Act of 1978, as amended (D.C. Official Code §7-1201.01 *et seq.*).
5. Copies of each form will be given to the consumer, and the original forms must be filed in the consumer’s clinical record.

The provisions in these forms shall take precedence over any corresponding provisions in the DMH Privacy Policies and Procedures Manual until the manual is updated in its entirety.

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

Policy Clearance. Reviewed by affected responsible staff, including DMH General Counsel and DMH Privacy Officer.

Implementation Plans. A plan of action to implement or adhere to this transmittal must be developed by designated responsible staff. If materials and/or training are required to implement this transmittal, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. *This transmittal is effective immediately.*

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this transmittal and begin using the attached revised forms, dated June 1, 2012, immediately.

Each staff person who maintains policy manuals must promptly file this transmittal with their **DMH** Policy and Procedures, and contractors must ensure that this transmittal is maintained in accordance with their internal procedures. *A copy of this transmittal must also remain in the DMH Privacy Policies and Procedures Manual, which must be located in all programs that use and disclose protected health information (PHI).*

ACTION

REMOVE AND DESTROY

DMH-HIPAA Form 1, dated 06/03
DMH-HIPAA Form 2, dated 06/03
DMH-HIPAA Form 3, dated 10/31/11

INSERT

This transmittal and the attached revised DMH HIPAA Forms 1, 2, and 3, dated 06/01/2012, in the DMH Privacy Policies and Procedures Manual, dated July 16, 2003



Stephen T. Baron (Date)
Director, DMH



Joint Notice of Privacy Practices

THIS NOTICE IS EFFECTIVE AS OF JUNE 1, 2012

If you do not speak and/or read English or if you have a hard time understanding this document, please call the DMH Access Helpline at 1-888-793-4357 or (202) 561-7000 or TTY/TDD: at (202) 673-7500. A representative will assist you 24 hours a day 7 days a week.

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI), INCLUDING MENTAL HEALTH INFORMATION, ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Department of Mental Health (DMH) Network includes DMH and all mental health providers that are certified, licensed, or otherwise regulated by DMH or have entered into a contract or agreement with DMH to provide mental health services or supports. This notice tells you how your PHI will be used, shared, and protected by the participating Network providers.

What is PHI? PHI is any written, recorded, or oral information which either:

- identifies, or could be used to identify, a consumer; or
- relates to (1) the physical or mental health or condition of a consumer, (2) provision of health care to a consumer, or (3) payment for health care provided to a consumer.

CONSENT FOR USES AND DISCLOSURES OF YOUR PHI AMONG NETWORK PROVIDERS

With your written consent, Network providers will share your PHI with each other as necessary to carry out treatment, payment, or health care operations.

What can be done with my PHI if I consent to disclose it for purposes of treatment, payment, or healthcare operations?

For treatment: Network providers can share your PHI with other Network providers so that you can receive the most appropriate treatment. For example, if the agency that is treating you determines that you need a service that it cannot provide, then your agency could send your PHI to another Network provider who can provide the service so that you can receive the treatment you need. Network providers may also contact you to provide appointment reminders.

For payment: Network providers can share information about when and why you were seen, so that they can be paid for treating you. For example, in order to be paid, Network providers can send information to Medicaid or to your health insurance company stating when and why you were being treated.

For health care operations: Network providers may use your PHI for health care operations such as evaluating the quality of services provided or investigating unusual incidents. For example, DMH may review selected charts every month to monitor the quality of the services being provided.

Can I revoke my consent to have my PHI shared among Network Providers?

Yes. You can revoke your consent at any time 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 consent until the Network provider receives your revocation in writing. The revocation of your consent will not affect any action by the Network provider before it was received.

**USES AND DISCLOSURES OF YOUR PHI WITHOUT YOUR CONSENT
OR AUTHORIZATION**

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

Your PHI can be shared without your prior consent or authorization in the following situations:

- To meet the mandatory reporting requirements of local or federal laws on human health and safety, including laws that require us to report suspected abuse or neglect;
- When a mental health professional believes its necessary to ask for emergency psychiatric hospitalization, or to protect you or someone else from serious physical harm;
- For health oversight activities such as evaluating programs and audits;
- For certain judicial and administrative proceedings;
- In response to a court order;
- For research purposes, such as research related to the development of better treatments, provided the research study meets certain privacy requirements;
- To meet the investigative and oversight requirements of any other local or federal laws that apply to privacy of health information;
- 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;
- At the request of your legal representative;
- To correctional institutions or law enforcement officials having lawful custody of you in order to facilitate the delivery of mental health services and supports; and
- To monitor your compliance with a condition of pretrial release, probation, parole, supervised release, or diversion agreement regarding mental health treatment.

**ANY OTHER USES AND DISCLOSURES OF YOUR PHI
THAT REQUIRES YOUR PERMISSION**

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 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 for other purposes, 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.

OUR DUTY TO PROTECT YOUR PHI

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.

YOUR RIGHTS REGARDING YOUR PHI

What rights do I have concerning my PHI?

- 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 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.

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 one or both of the organizations listed below:

DMH Privacy Officer
D.C. Department of Mental Health
609 H Street, NE, 4th Floor
Washington, D.C. 20002
(202) 671-4088
TTY/TTD: (202) 673-7500
E-mail: dmh.privacy@dc.gov

District-wide Privacy and Security Official
Office of Attorney General
441 4th Street, NW, 11th Floor
Washington D.C. 20001
(202) 442-9373
TTD: (202) 724-5055
TTY: (202) 727-3363
E-mail: dcprivacy@dc.gov or tina.curtis@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
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

You always have the right to file a grievance through the DMH grievance procedures. No one may take any action against you for complaining about the use and disclosure of your PHI.

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) created or received before the notice was changed. The amended notice will be posted on the DMH 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 confirm that I have been offered a copy of the DMH 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 _____

_____ **I refuse to sign this form.**

Note to Network personnel:

If consumer/representative refuses Notice or 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
Original Acknowledgement form – Clinical Record

JOINT CONSENT FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Including Mental Health Information) AMONG PARTICIPATING NETWORK PROVIDERS

The purpose of this form is to obtain your consent in writing for the use and disclosure of medical information about you so that we may arrange to provide you with treatment, to get paid for that treatment, and to carry out other healthcare activities. Please read this form carefully and ask any questions you wish.

- I understand that local and federal laws protect the privacy of my protected health information (PHI). My PHI includes any information, past, present, or future, about my mental or physical health; about treatment I receive for a mental or physical condition; or about payment for that treatment.
- I understand that the Department of Mental Health (DMH) Network - - which includes DMH and all the providers of mental health treatment and services that DMH contracts with or regulates - - has to follow those laws in using, sharing, and protecting my PHI.
- I understand that, under those laws, the Network providers need my consent to use and share my PHI with each other in order to provide me with treatment, to get paid for my treatment, and to carry out other healthcare activities. By signing this consent form I give them permission to share my information for those purposes.
- I understand that I have the right to see and keep a copy of the Network's Joint Notice of Privacy Practices before I am asked to sign this consent form. The Joint Notice of Privacy Practices provides a more complete description of when and how the Network providers can use and disclose my PHI under the law.
- I understand that, even though I give my consent, I have the right to ask that the Network providers place certain limits on their use and disclosure of my PHI. They do not have to agree to those limits, but, if they do agree, they must follow those limits.
- I understand that I have the right to revoke this consent if I change my mind later, but I must do so in writing and give it to the agency that is providing me treatment or to the:

DMH Privacy Officer
609 H Street, NE, 4th Floor, Washington, D.C. 20002
Phone: (202) 671-4088; e-mail: dmh.privacy@dc.gov

Once they receive my written revocation, the Network providers must stop sharing my PHI. In the meantime, DMH and the participating Network providers are free to share my PHI with each other in order to treat me, to be paid for my treatment, and to carry out other healthcare activities.

SIGNATURE OF CONSUMER OR PERSONAL REPRESENTATIVE:

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

Signature _____ Date _____

Print or type full name _____

AUTHORITY TO ACT ON BEHALF OF CONSUMER (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.*

VERIFICATION OF IDENTITY – REQUIRED

- Personal identification (government issued photo ID) *Attach a copy.*
- Government official or Network provider's oral representation. *Attach a copy of the Government official or Network Provider's ID. State what you were told and why your reliance on it was reasonable in the circumstances.*

_____.

I have verified the identity of the person providing consent.

Signature _____ Date _____

Print Name _____ Title _____

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.

I revoke this authorization effective _____ Signature _____
(Consumer, or personal representative and relationship to consumer)

**Authorization
to Use or Disclose Protected Health Information,
(Including Mental Health Information)**

Name of Consumer (type or print) _____ Identification Number _____

Address _____ Date of Birth _____

City/State/Zip Code _____ Other name(s) used _____

<u>RELEASE INFORMATION TO:</u>	<u>INFORMATION TO BE RELEASED BY:</u>
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 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 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.

I revoke this authorization effective _____ Signature _____
(Consumer, or personal representative and relationship to consumer)

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.

OTHER RIGHTS: 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 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.

Signature _____ Date _____

Print or type full name _____

AUTHORITY TO ACT ON BEHALF OF CONSUMER (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 is at least 14 years of age, but under 18 years of age, this authorization is not valid unless the consumer signs in addition to the parent/legal guardian/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.

Signature of Minor _____ Date _____

Print or type full name _____ DOB _____ Phone # _____

Address: _____

VERIFICATION OF IDENTITY OF CONSUMER OR PERSONAL REPRESENTATIVE PROVIDING CONSENT - REQUIRED

- Personal identification (government issued photo ID) *Attach a copy.*
- Government official or Network provider's oral representation. _____

State what you were told and why your reliance on it was reasonable in 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/her signature notarized or attach a copy of his/her government issued ID.

I Have Verified the Identity of the Person Providing Consent.

Signature _____ Date _____

Print Name _____ Title _____

TO THE RECORDS CUSTODIAN:

1. Provide a copy of this authorization to the consumer 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