Client Name		Chart Number	

NOTICE OF PRIVACY PRACTICES S3D2

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN BET ACCESS TO THIS INFROMATION.

Progressive CCC, LLC HAS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION. All employees, volunteers, staff, doctors, health professionals, and other personnel are legally required to abide by the policies set forth in this notice, and to protect the privacy of your health information. This "protected health information" includes information that can be used to identify you. We collect or receive this information about your past, present, or future health condition to provide health care to you, or to receive payment for healthcare. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose (release) your Protected Health Information. With some exceptions, we may not use or release any more of your Protected Health Information than is necessary to accomplish the need for the information. We must abide by the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the Protected Health Information already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy from the contact person listed at the end of this notice at any time. **WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION** for many different reasons. Below, we describe the different categories of when we use and release your Protected Health Information without your consent.

A. **WE MAY USE, OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.**
    1. **For Treatment.** We may share your Protected Health Information among physicians, nurses, psychologists, social workers, interns, and other health care personnel who are directly involved in your health care at this clinic. For example: your primary therapist and your medication provider will share your Protected Health Information to provide the best care for you For external disclosures e will always ask for your authorization before we disclose your health information, except in emergencies to EMS or other mental health agencies or units.
    2. **To obtain payment for treatment.** We may use and release your Protected Health Information in order to bill and collect payment from you for services provided to you. It is important that you provide us with correct and up-to-date information. For example, we may release portions of your Protected Health Information to our billing department to get paid for health care services we provided to you. We may also release your Protected Health Information to our business associates, such as billing companies.
    3. **To run our healthcare business.** We may use your Protected Health Information internally, in order to

operate our facility in compliance with healthcare regulations. For example, we may use your Protected Health Information to review the quality of our services and to evaluate the performance of our staff in caring for you.

B. WE DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PROTECTED HEALTH INFORMATION WHEN:

1. **When federal, state, or local law, judicial or administrative proceedings, or law enforcement agencies request your Protected Health Information**. We release your Protected Health Information only when a law requires that we report information to government agencies or law enforcement personnel. Specifically, we would notify the State of Louisiana Child Abuse Registry about victims of child abuse, r neglect. We would also notify Law enforcement officials about the following: for notification and identification purposes when a crime has occurred; in missing person cases; or when ordered in a judicial or administrative proceeding.
2. **About Decedents.** We provide coroners/medical examiners at their request necessary information relating to an individual's death.
3. **To avoid harm.** In order to avoid a serious threat to your safety or the safety of another individual, we may provide your Protected Health Information to law enforcement personnel, or to the endangered person, or to other people able to prevent or lessen such harm.
4. **For appointment reminders and health-related benefits and services.** We may use your demographic Protected Health Information to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternative that may be of interest to you.
5. **For health oversight activities.** We repot information about serious incidents, including deaths, to the Louisiana State Office of Mental Health. We may use and disclose your Protected Health Information to a health oversight agency, including Louisiana State Office of Mental Health, Medicaid, Medicare, or your Health Insurance Plan, for oversight activities authorized by law including audits, licensure, or other activities necessary for oversight of the health care system or disciplinary actions against our workforce.

C. YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT INCLUDED ABOVE.

1. **To obtain payment from your health care plan for treatment.** Pending your signed consent for release of information and payment for medical benefits form , we may use and release your Protected Health Information to your health plan in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date information.
2. **Information shared with family, friends, or others.** We will only release your Protected Health Information to a family member, friend, or other person that you indicate is involved in your care if you agree to the disclosure by completing and signing an Authorization Form. We will ask for your written

authorization before using or releasing any of your Protected Health Information. If you choose to sign an authorization to release your Protected Health Information you may later cancel that authorization in writing. This will stop any future release of your Protected Health Information for the purposes you previously authorized.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. **You have the right to request limits on how we use and release your Protected Health Information.** If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit Protected Health Information that we are legally required or allowed to release.

B. **You have the right to choose how we communicate Protected Health Information to you. All** of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, sening information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the form that you requested. Any additional expenses will be passed onto you for payment.

C. **You have the right to request to see and get copies of your Protected Health Information.** You must make the request in writing. We will respond to you within 110 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you in writing, why we denied your request. You may have the right to have the denial reviewed by a committee. You can request a summary or a copy of your Protected Health Information as long as you agree to the cost in advance. If your request to see your Protected Health Information is approved, we will arrange this in accordance with established policy. Please submit all requests for this information to the Operations Manager.

D. **You have the right to get a list of instances of when and to whom we have disclosed your Protected Health Information.** This list will not include uses you have already authorized, or those for treatment, payment or operations. We will respond within 60 days of receiving your request. This list will include dates when your Protected Health Information was released and the purpose, with who the Protected Health Information was released (including their address if known), and the description of the information released. Please submit all requests for this information to the Program Coordinator.

E. **You have the right to correct or update your Protected Health Information.** If you believe that there is a mistake in your Protected Health Information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 60 days of your request. If we deny your request, our written denial will state our reasons and explain your right to file a written statement of disagreement. If you do not file a written

statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or releases of your Protected Health Information. If we approve your request, we will make the change to your Protected Health Information, tell you that we have done it, and tell others that need to know about the change or amendment to your Protected Health Information. Please submit all requests for this information to the Chief Executive Officer.

F. **You have the right to receive this Privacy Notice.** You have the right to request another copy at any time.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRVIACY PRACTICES: If you think that we have violated your privacy right, or you disagree with a decision we made about access to your Protected Health Information, you may file a complaint with our Privacy Official. You may also send a written complaint to the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below I acknowledge that I have received a copy of the "Notice of Privacy Practices."

Recipient Name (Print)			
Recipient Signature		**Date**	

If the recipient is under the age of 18, this form must also be signed by the parent/guardian.

Parent/Guardian Name (Print)			
Parent/Guardian Signature		**Date**	

I certify that all questions regarding the privacy practices policy have been answered.

PCCC Staff Name, Title (Print)			
PCCC Staff Signature		**Date**	