



PATHWAY CLINIC



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Pathway Clinic, S.C., and REDI Clinic, must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy.

Without your written authorization, we can use your health information for the following purposes:

1. ***Treatment.*** For example, a doctor or therapist may use the information in your clinic record to determine which treatment option best addresses your health needs. The treatment selected will be documented in your clinic record, so that other health care professionals can make informed decisions about your care.
2. ***Payment.*** In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the dates and types of services received. As a result, we will pass this information on to an insurer in order to help receive payment for your treatment.
3. ***As required or permitted by law.*** Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.
4. ***For public health activities.*** We may be required to report certain information to authorities. This may include using your clinic record to report death information or information related to child abuse or neglect.
5. ***To avoid a serious threat to health or safety.*** As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.
6. ***For workers' compensation.*** We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information.

If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to the office manager.

Please see other side...



PATHWAY CLINIC



Your Health Information Rights

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact Pathway Clinic or REDI Clinic office staff. Specifically, you have the right to:

1. ***Inspect and copy your health information.*** With a few exceptions, you have the right to inspect and obtain a copy of information in your clinic file(s). However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information.
2. ***Request to correct your health information.*** If you believe your health information is incorrect, you may ask us to correct the information. You may be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.
3. ***Request restrictions on certain uses and disclosures.*** You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. However, we are not required to agree in all circumstances to your requested restriction.
4. ***As applicable, receive confidential communication of health information.*** You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.
5. ***Receive a record of disclosures of your health information.*** In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, health care operations, and law enforcement/corrections.
6. ***Obtain a paper copy of this notice.*** Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically.
7. ***Complain.*** If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services, within 180 days of the violation. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact the Pathway Clinic and REDI Clinic Privacy Officer, who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact the Privacy Officer at (414) 727-4455.

This Notice of Health Information Privacy is Effective April 14, 2003.



PATHWAY CLINIC



HIPPA Privacy and Disclosure Policy Notice Receipt

A. Written Acknowledgement of Receipt of Pathway Clinic/The REDI Clinic Privacy and Disclosure Notice.

By signing this form, you acknowledge that Pathway Clinic, S.C., or REDI Clinic, has given you a copy of their Privacy Notice, which explains how your health information will be handled in various situations.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

- I have received Pathway Clinic’s or REDI Clinic’s Privacy Notice.**
- Pathway Clinic, S.C., or REDI Clinic, has given me the chance to discuss my concerns and questions about the privacy of my health information.**

Print Client Name: _____

Client/Parent Signature: _____
Date

Witness Signature: _____
Date

B. Consent to Pathway Clinic/The REDI Clinic Privacy and Disclosure Notice.

I agree to the Privacy an Disclosure Policy of Riverview Psychotherapy, and to the practices described therein, regarding the collection, storage, use and transmission of protected health information in the course of treatment, billing and collections and other health care procedures, as described above.

Print Client Name: _____

Client/Parent Signature: _____
Date

Witness Signature: _____
Date