Family Service Agency
Strengthening Individuals & Families

Family Service Agency
Notice of Privacy Practices

We respect our client's confidentially and only release information about you in accordance with state and federal laws.

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

This notice describes our policies related to the use of records of your care at the Family Service Agency, hereafter referred to as FSA. We are required to give you this Notice about (1) the use and disclosure of your health information; (2) our legal responsibilities and (3) your rights concerning your health information and to abide by the terms of this notice.

You may request a copy of this notice at any time. For more information about our privacy practices, or for additional information, contact FSA at (815) 758-8616.

1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We use and disclose the minimum necessary health information about you for your treatment, and for payment for your services.

a. **For Treatment.** There may be times when it is advisable to share information with other health care providers to coordinate treatments or for purposes of referral. If this is necessary, you will sign an authorization for release of information.
b. **For Payment.** We may use and disclose your health information to obtain payment for services we provide to you. For example, we may need to give insurance companies or other agencies the minimum necessary information in order for them to pay us for the service we have provided to you.

2. INFORMATION DISCLOSED WITHOUT YOUR CONSENT

Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

a. **Emergencies.** Sufficient information may be shared to address an immediate emergency.
b. **Judicial and Administrative Proceedings.** We may disclose your personal health information in the course of a judicial or administrative proceeding in response to a valid order or other lawful process, if you were to make a claim for Workers Compensation.
c. **Public Health Activities.** If we believe you are in immediate danger to yourself or others, we may disclose health information about you to the person or persons reasonably able to prevent or lessen the threat, as well as alert any other person who may be in danger.
d. **Child/Elder Abuse.** We are mandated to disclose health information about you related to the suspicion of child and/or elder abuse or neglect.
e. **Criminal Activity or Danger to Others.** We may disclose health information if a crime is committed on our premises or against our personnel or if we believe there is someone who is in immediate danger.
f. **National Security, Intelligence Activities and Protective Services to the President and Others.** We may release health information about you to federal officials as authorized by law in order to protect the President or other national or international figures or in case of national security.
g. **Marketing.** FSA may send you newsletters or information about services we provide in which we feel you might be interested. You may, at any time, request that your name be removed from our mailing list. *We will not disclose information to others for use in direct mail marketing or electronic mail.*
h. **Scheduling Appointments.** FSA may use your phone number to call you and leave messages to schedule or remind you of appointments.

3. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

a. **Right to Inspect and Copy.** You have the right to look at or get copies of your health information, with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred.

b. **Right to Amend.** You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We have the right to deny your request under certain circumstances.

c. **Right to Accounting of Disclosures.** You have the right to receive a list of instances in which we have disclosed your health information for a purpose other than treatment, payment or health care operations. To request an accounting of disclosure, you must submit your request in writing to your counselor. Such accountings are available for disclosure beginning April 14, 2004, and remain available for six years after the last date of service at FSA.

d. Rights to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, your could ask that we not share information with an insurance company, in which case you would be responsible to pay in full for the services provided. A written request should be made with your counselor. We are not required to agree with your request, but we will consider the request very seriously. If we agree, we will abide by our agreement unless the information is needed in an emergency by law.

e. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will make every attempt to accommodate reasonable requests.

f. **Right to Obtain Paper Copy of this Notice.** You have the right to receive a paper copy of this notice and any amended notice upon request. Copies will be available from the counselor.

Any other uses and disclosures not set out in the information above will be made only with your written authorization. You may revoke a written authorization for release of information at any time. The revocation must be in writing and will become effective when it has been received by your coordinator and will only be for disclosures not already completed.

We reserve the right to change our privacy practices provided such changes are permitted to applicable law. Before the effective date of a material change, however, we will change this Notice and make a new Notice available to you. Beginning April 14, 2004, we are required to abide by the terms of this Notice.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, or you may file a complaint with the US Department of Health & Human Services. To obtain additional information or to file a complaint with us, contact your counselor at (815) 758-8616. We will not retaliate in any way if you choose to file a complaint.

Client Name:_____

Date of Birth: _____ SSN: _____

I hereby acknowledge that I have been given an opportunity to read a copy of FSA's Notice of Privacy Practices. I understand that if I have any questions regarding this Notice or my privacy rights, I can contact my counselor at FSA.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Employee (if Client or Guardian refuses to acknowledge receipt) Date