

# **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT COVER SHEET**

Please have the consumer complete this cover sheet, and then tear off this cover sheet and file it in the consumer's medical record.

I, \_\_\_\_\_ (have client write name, or request staff assistance to do so), hereby acknowledge that I have received this Notice of Privacy Practices, with an effective date of April 14, 2009.

\_\_\_\_\_  
CONSUMER SIGNATURE OR  
LEGAL GUARDIAN SIGNATURE  
OR PARENT OF MINOR CHILD  
SIGNATURE

\_\_\_\_\_  
DATE

**Notice Effective Date: 4/14/08**  
**Document Updated: 1.28.2019**

# **Dismas House of Kansas City**

## **NOTICE OF PRIVACY PRACTICES**

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

This notice is to explain the rules around the privacy of your own medical/health records and our legal duties on how to protect the privacy of your medical/health records that we create or receive. Generally, we are required by law to ensure that medical/health information that identifies you is kept private. We are required by law to follow the terms of the notice that are the most current.

This notice will explain:

- how we may use and disclose your medical/health information,
- our obligations related to the use and disclosure of your medical/health information and
- your rights related to any medical/health information that we have about you.

This notice applies to the medical/health records that are generated in or by this facility. The terms “medical” and “medical/health” in this Notice means information about your physical or mental condition which make you eligible for our services, or which arise while we are serving you. For example, this may include psychological tests, psychiatric assessments or medical or social assessments.

We may obtain, but we are not required to, your consent for the use or disclosure of your protected health information for treatment, payment or health care operations. We are required to obtain your authorization for the use or disclosure of your information for other specific purposes or reasons. We have listed some of the types of uses or disclosures below. Not every possible use or disclosure is covered, but all of the ways that we are allowed to use and disclose information will fall into one of the categories.

If you have any questions about the content of this Notice of Privacy Practices, or if you need to contact someone at the facility about any of the information contained in this Notice of Privacy Practices, the contact person is the Privacy Officer or designee:

**Dismas House of Kansas City**  
**Attention: Sheriece Miller**  
**2300 Main Street, 9<sup>th</sup> Floor**  
**Kansas City, MO 64108**

In addition to facility departments, employees, staff and other facility personnel, the following people will also follow the practices described in this Notice of Privacy Practices:

- Any health care professional who is authorized to enter information in your medical/health record;
- Any member of a volunteer group that we allow to help you while you are in the facility; and
- All providers that the Department of Mental Health contracts with to provide [direct treatment](#) services to our consumers.

In addition, individuals and providers may share medical information with each other about DMH

consumers they serve in common for the purpose of treatment, payment or health care operations as those terms are described later in this Notice of Privacy Practices.

## **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

The following categories describe different ways that we use and disclose medical/health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

### **Use and Disclosure of Medical Information**

We can use or disclose medical information about you regarding your treatment, payment for services, or for facility operations, and we will make a good faith effort to have you acknowledge your copy of the Notice of Privacy Practices.

**Treatment** We may use medical (protected health information, or PHI) information about you to provide you with treatment or services. We may disclose medical information about you to qualified mental health professionals, or QMHPs; qualified mental retardation professionals or QMRPs; or to qualified counselors; or, technicians, medical students or residents, or other facility personnel, volunteers or interns who are involved in providing services for you at the facility, or interpreters needed in order to make your treatment accessible to you. For example, your treatment team members will internally discuss your medical/health information in order to develop and carry out a plan for your services. Different departments of the facility also may share medical/health information about you in order to coordinate the different things you need, such as prescriptions, medical tests, special dietary needs, respite care, personal assistance, day programs, etc. We also may disclose medical/health information about you to people outside the facility who may be involved in your medical care after you leave the facility, such as community health/mental health/developmental disability/substance abuse providers or others we use to provide services that are part of your care, but only the minimum necessary amount of information will be used or disclosed to carry this out. Please note that the definition of treatment does allow DMH to share PHI when necessary to consult with other providers, or when necessary to refer you to another provider, or even to treat a different individual.

**Payment** We may use and disclose medical/health information about you so that the treatment and services you receive at the facility may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to provide your insurance plan information about psychiatric treatment or habilitation services you received at the facility so your insurance plan, or any applicable Medicaid or Medicare funds, will pay us for the services. We may also tell your insurance plan or other payor about a service you are going to receive in order to obtain prior approval or to determine whether the service is covered. In addition, in order to correctly determine your ability to pay for services, we may disclose your information to the Social Security Administration, the Division of Employment Security, or the Department of Social Services.

**Health Care Operations** We may use and disclose medical/health information about you for facility operations. These uses and disclosures are necessary to run the facility or the Department of Mental Health and make sure that all of our consumers receive quality care. For example, we may use medical/health information for quality improvement to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many facility consumers to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students and residents, and other facility personnel as listed above for review and

learning purposes. We may also combine the medical/health information we have with medical/health information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. It may also be necessary to obtain or exchange your information with the Department of Elementary and Secondary Education, the Department of Social Services, Vocational Rehabilitation, the Office of State Courts Administrator, or other Missouri state agencies or interagency initiatives, such as the Juvenile Information Governance Commission, or System of Care initiative. Or, we may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of specific consumers. This may be in the form of providing information to our regional advisory councils or state advisory councils or planning councils.

**Other Uses and Disclosures of Medical/Health Information That Do **Not** Require Your Consent or Authorization:**

We can use or disclose health information about you without your consent or authorization when:

- there is an emergency or when we are required by law to treat you,
- when we are required by law to use or disclose certain information, or
- when there are substantial communication barriers to obtaining consent from you.

We can also use or disclose health information about you without your consent or authorization for:

**Appointment Reminders** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or services at the facility.

**Treatment Alternatives and Health-Related Benefits and Services** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives or health-related benefits or services that may be of interest to you.

**Individuals Involved in Disaster Relief** Should a disaster occur, we may disclose medical information about you to any agency assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

or Privacy Committee. *For example, a research project may involve comparing the health and recovery of all consumers who received one medication to those who received another for the same condition.* All research projects, however, are subject to a special approval process under Missouri law. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with consumers' need for privacy of their medical/health information. Before we use or disclose medical/health information for research, the project will have been approved through this research approval process. We may, however, disclose medical/health information about you to people *preparing* to conduct a research project, for example, to help them look for consumers with specific medical needs, so long as the medical information they review does not leave the facility. We may also use or disclose your health information without your consent when disclosing information related to a research project when a waiver of authorization has been approved by the Professional Review Committee or a university sponsored Institutional Review Board.

**As Required By Law** We will disclose medical/health information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety** We may use and disclose medical/health information about you when necessary to prevent a serious threat to the health and safety of you, the public, or any

other person. However, any such disclosure would only be to someone able to help prevent the threat.

## **SPECIAL SITUATIONS**

**Organ and Tissue Donation** If you are an organ donor, we may release medical/health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans** If you are a member of the armed forces, we may release medical/health information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation** When disclosure is necessary to comply with Workers' Compensation laws or purposes, we may release medical/health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks** We may disclose medical/health information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a consumer has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities** We may disclose medical/health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes** If you are involved in a lawsuit or a dispute, we may disclose medical/health information about you in response to a court or administrative order.

**Law Enforcement** We may release medical/health information if asked to do so by a law enforcement official; however, if the material is protected by 42 CFR Part 2 (a federal law protecting the confidentiality of drug and alcohol abuse treatment records), a court order is required. We may also release limited medical/health information to law enforcement in the following situations: (1) about a consumer who may be a victim of a crime if, under certain limited circumstances, we are unable to obtain the consumer's agreement; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the facility; (4) about a consumer where a consumer commits or threatens to commit a crime on the premises or against program staff (in which case we may release the consumer's name, address, and last known whereabouts); (5) in emergency circumstances, to report a crime, the location of the crime or victims, and the identity, description and/or location of the person who committed the crime; and (6) when the consumer is a forensic client and we are required to share with law enforcement by Missouri statute.

**Coroners, Medical Examiners and Funeral Directors** We may release medical/health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical/health information about consumers of a facility to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities

authorized by law.

**Protective Services for the President and Others** We may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the President and other authorized persons or foreign heads of state.

**Inmates** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical/health information about you to the correctional institution or law enforcement official if the release is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

### **Emergency or Disaster Events**

In the interest of public safety and planning for community needs in an emergency or disaster event, we may disclose general information about you to emergency managers, fire, law enforcement, public health authorities, emergency medical services such as ambulance districts, utilities, and other public works officials regarding:

- The numbers and locations of DMH clients in community and state-operated settings;
- Any special needs identified in these settings for purposes of rescue such as sensory, cognitive and mobility impairments;
- Special assistance and supports needed to effectively meet these needs such as communication devices, specialized equipment for evacuation, etc;
- Necessary information to order necessary treatment or prophylaxis supplies and medications in the event of a public health emergency;
- Emergency notification contacts to expedite contact with families, legal guardians or representatives or others regarding need for evacuation or emergency medical care;
- Any special needs that justify prioritization of utility restoration such as but not limited to dependence on respirator or other medical equipment, phone for emergency contact, etc.; or
- Any other information that is deemed necessary to protect the health, safety and well-being of DMH consumers.

### **YOUR RIGHTS REGARDING MEDICAL/HEALTH INFORMATION ABOUT YOU.**

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy** You have the right to inspect and copy your medical/health information *with the exception of psychotherapy notes and information compiled in anticipation of litigation*. To inspect and copy your medical/health information, you must submit your request in writing to this facility's Privacy Officer or designee. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your medical/health information because of a threat or harm issue, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Request an Amendment** If you feel that medical/health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Requests for an amendment must be made in writing and submitted to the Privacy Officer or designee. You must provide a reason to support

your request for an amendment. We may deny your request if it is not in writing or if it does not include a reason supporting the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the facility;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

**Right to an Accounting of Disclosures** You have the right to request an "accounting of disclosures", a list of the disclosures made by the facility of your medical/health information. To request an accounting of disclosures, you must submit your request in writing to this facility's Privacy Officer or designee. Your request must state a time period which may not go back more than six years and cannot include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists in a twelve-month period, we may charge you for the cost of providing the list. We will notify you what that cost will be and give you an opportunity to withdraw or modify your request before you are charged. There are some disclosures that we do not have to track. For example, when you give us an authorization to disclose some information, we do not have to track that disclosure.

**Right to Request Restrictions** You have the right to request a restriction or limitation on the medical/health information we use or disclose about you for treatment, payment or health care operations. For example, you could ask that we not use or disclose information about your family history to a particular community provider. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restrictions on the use or disclosure of your medical/health information for treatment, payment or health care operations, you must make your request in writing to the facility's Privacy Officer or designee. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

**Right to Request Confidential Communications** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the facility's Privacy Officer or designee. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request and will accommodate all reasonable requests.

**Right to a Paper Copy of This Notice** You have the right to a paper copy of this notice even if you have agreed to receive the notice electronically. You may ask us to give you a copy of this notice at any time by contacting the facility's Privacy Officer or designee. You may also obtain a copy of this notice at our website, <http://www.dmh.mo.gov/>

**If you wish to exercise any of these rights, please contact:**

**Dismas House of Kansas City  
Attention: Sheriece Miller  
2300 Main Street, 9<sup>th</sup> Floor  
Kansas City, MO 64108**

#### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We may make the revised notice effective for medical/health information we already have about you as well as any information we receive in the future. We will post a

copy of the current notice in the facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted or apply for services to the facility for treatment or services, we will offer you a copy of the current notice in effect. If you want to request any revised Notice of Privacy Practice, you may access it at our website, <http://www.dmh.mo.gov/>

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may:

- File a complaint with the facility, contact Privacy Officer or Designee, at the following address and telephone number.

**Dismas House of Kansas City**  
**Attention: Sheriece Miller**  
**2300 Main Street, 9<sup>th</sup> Floor**  
**Kansas City, MO 64108**  
**Phone: 816-256-5330**

- File a complaint with the Region VII, Office for Civil Rights (OCR), U.S. Department of Health and Human Services. You may call them at 816.426.7278 or write to them at 601 East 12<sup>th</sup> Street, Room 248, Kansas City, Missouri, 64106. You may also fax your complaint to the Region VII, Office for Civil Rights (OCR) by calling 816.426.3686, or 816.426.7065 TTY

File written complaints with the Department of Health and Human Services Office for Civil Rights (OCR) by **mail, fax, or email**. If you need help filing a complaint or have a question about the complaint form, please call this OCR toll free number: 1-800-368-1019.

You can submit your complaint in any written format. It is recommended that you use the OCR Health Information Privacy Complaint Form which can be found on our web site or at an OCR Regional office. If you prefer, you may submit a written complaint in your own format. Be sure to include the following information in your *written* complaint:

- **If you are filing a complaint on someone's behalf, also provide the name of the person on whose behalf you are filing.**
- **Name, full address and phone of the person, agency or organization you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule.**
- **Briefly describe what happened. How, why, and when do believe your (or someone else's) health information privacy rights were violated, or the Privacy Rule otherwise was violated?**

**Any other relevant information.**

**Please sign your name and date your letter.**

### **The following information is optional:**

- **Do you need special accommodations for us to communicate with you about this complaint?**
- **If we cannot reach you directly, is there someone else we can contact to help us reach you?**
- **Have you filed your complaint somewhere else?**

The Privacy Rule, developed under authority of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), prohibits the alleged violating party from taking retaliatory action against anyone for filing a complaint with the Office for Civil Rights. You should notify OCR immediately in the event of any retaliatory action.

*To submit a complaint with OCR, please use one of the following methods.* If you mail or fax the complaint, be sure to follow the instructions above for determining the correct regional office.

*Option 1:* Open and print out the [Health Information Privacy Complaint Form](#) in PDF format (you will need Adobe Reader software) and fill it out. Return the completed complaint to the appropriate OCR Regional Office by mail or fax.

*Option 2:* Download the [Health Information Privacy Complaint Form](#) in Microsoft Word format to your own computer; fill out and save the form using Microsoft Word. Use the Tab and Shift/Tab on your keyboard to move from field to field in the form. Then, you can either: (a) print the completed form and mail or fax it to the appropriate OCR Regional Office; or (b) email the form to OCR at [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov).

*Option 3:* If you choose not to use the OCR-provided Health Information Privacy Complaint Form (although we recommend that you do), please provide the information specified above and either: (a) send a letter or fax to the appropriate OCR Regional Office; or (b) send an email OCR at [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov).

If you require an answer regarding a general health information privacy question, please view our Frequently Asked Questions (FAQs). If you still need assistance, you may call OCR (toll-free) at: 1-866-627-7748. You may also send an email to [OCRPrivacy@hhs.gov](mailto:OCRPrivacy@hhs.gov) with suggestions regarding future FAQs. Emails will not receive individual responses.

**Website:** <http://www.hhs.gov/ocr/hipaa>

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

#### **OTHER USES OR DISCLOSURES OF MEDICAL/HEALTH INFORMATION.**

Uses or disclosures not covered in this Notice of Privacy Practices will not be made without your written authorization. If you provide us written authorization to use or disclose information, you can change your mind and revoke your authorization at any time, as long as it is in writing. If you revoke your authorization, we will no longer use or disclose the information. However, we will not be able to take back any disclosures that we have made pursuant to your previous authorization.