

THE CHILDREN'S CENTER OF HAMDEN, INC  
1400 Whitney Avenue, Hamden, CT 06517 (203)248-2116

**NOTICE OF PRIVACY PRACTICES**  
**THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION  
ABOUT YOU MAY BE USED AND DISCLOSED AND  
HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**If you have any questions about this notice, please call Sarah Lockery, ext 283  
The effective date of this privacy notice is April 14, 2003, revised June 13, 2013**

At The Children's Center of Hamden, we respect the privacy and confidentiality of your health information. This Notice of Privacy Practices ("Notice") describes how we may use and disclose your medical/health information and how you can get access to this information. This Notice applies to uses and disclosures we may make of all your health information whether created or received by us.

**I. OUR RESPONSIBILITIES TO YOU**

We are required by law to:

1. Maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices relating to your health information.
2. Comply with the terms of our Notice currently in effect.

We reserve the right to change our practices and to make the new provisions effective for all health information we maintain, including both health information we already have and health information we create or receive in the future. Should we make material changes, we will make the revised Notice available to you by posting it on our agency website and on our main bulletin board in the Wakeman Hall building.

3. We will notify you of any breaches of your health information.

**II. HOW WE WILL USE AND DISCLOSURE YOUR HEALTH INFORMATION  
FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

*(see Section VI for special rules regarding disclosure of  
psychiatric, substance abuse and HIV-related information)*

We may use and disclose your health information for purposes of treatment, payment and health care operations as described below:

1. **For Treatment.** We may use and disclose your health information to provide you with treatment and services and to coordinate your continuing care. Your health information may be

used by doctors and nurses, as well as by social workers, clinical therapists, lab technicians, dieticians or other personnel involved in your care, both within our facility and with other health care providers involved in your care. For example, a pharmacist will need certain information to fill a prescription ordered by your doctor. We may also disclose your health information to persons or facilities that will be involved in your care after you leave our facility or our care.

2. **For Payment.** We may use and disclose your health information so that we can bill and receive payment for the treatment and services you receive. For billing and payment purposes, we may disclose your health information to an insurance or managed care company, Medicare, Medicaid or another third party payor. For example, we may contact Medicaid or your health plan to confirm your coverage or to request approval for a proposed treatment or service.

3. **For Health Care Operations.** We may use and disclose your health information as necessary for our internal operations, such as for general administration activities and to monitor the quality of care you receive with us. For example, we may use your health information to evaluate and improve the quality of care you received, for education and training purposes, and for planning for services. Health information may be used to evaluate our employees and to review the qualifications and practices of practitioners at The Children's Center of Hamden, Inc.

### **III. OTHER USES AND DISCLOSURES WE MAY MAKE WITHOUT YOUR WRITTEN AUTHORIZATION**

We may make the following uses and disclosures without obtaining a written authorization from you:

1. **As Required By Law.** We may disclose your health information when required by law to do so.

2. **Persons Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose health information about you to a family member or identified guardian who is involved in your care. These disclosures are limited to information relevant to the person's involvement in your care or in arranging payment for your care.

3. **Public Health Activities.** We may disclose your health information for public health activities. These activities may include, for example, reporting to a public health authority for preventing or controlling disease, injury or disability; reporting elderly abuse or neglect; or reporting deaths.

4. **Reporting Victims of Abuse, Neglect or Domestic Violence.** If we believe that a minor child or youth has been a victim of abuse, neglect or domestic violence we are mandated by law to notify the Department of Children and Families, State of Connecticut. This notification may include a disclosure of the child/youth's health information.

5. **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law. A health oversight agency is a state or federal agency that oversees the health care system. Some of the activities may include, for example, audits, investigations, inspections and licensure actions.

6. **Judicial and Administrative Proceedings.** We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process, provided certain conditions are met. These conditions include making efforts to contact you about the request or obtaining an order or agreement protecting the health information.

7. **Law Enforcement.** We may disclose your health information for certain law enforcement purposes, including, for example, to file reports required by law or to report emergencies or suspicious deaths; to comply with a court order, warrant, or other legal process; to identify or locate a suspect or missing person; or to answer certain requests for information concerning crimes.
8. **Death.** We may release your health information to a coroner, medical examiner, funeral director and, if you are an organ donor, to an organization involved in the donation of organs and tissue.
9. **Research.** Your health information may be used for research purposes, but only if: (1) the privacy aspects of the research have been reviewed and approved by a special Privacy Board or Institutional Review Board and the Board can legally waive patient authorizations otherwise required; (2) the researcher is collecting information for a research proposal; (3) the research occurs after your death; or (4) if you give written authorization for the use or disclosure.
10. **To Avert a Serious Threat to Health or Safety.** When necessary to prevent a serious threat to your health or safety, or the health or safety of the public or another person, we may use or disclose your health information to someone able to help lessen or prevent the threatened harm.
11. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may also use and disclose health information about you if you are a member of a foreign military as required by the appropriate foreign military authority.
12. **National Security and Intelligence Activities; Protective Services for the Patient and Others.** We may disclose health information to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons or foreign heads of states or to conduct certain special investigations.
13. **Inmates/Law Enforcement Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the institution or official for certain purposes including your own health and safety as well as that of others.
14. **Workers' Compensation.** We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.
15. **Disaster Relief.** We may disclose health information about you to an organization assisting in a disaster relief effort.
16. **Fundraising Activities.** We may use and disclose certain limited health information such as your name, address and phone number and the dates you received treatment or services, to contact you in an effort to raise money for The Children's Center of Hamden, provided that any fundraising communications explain clearly and conspicuously your right to opt out of future fundraising communications. We are required to request your right to opt out.
17. **Business Associates.** Our business associates are individuals and organizations that carry out functions or activities on our behalf that involve protected health information. We may disclose your health information to our business associates who need the information to perform services for us. Our business associates are committed to preserving the confidentiality of this information.

#### **IV. YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR ALL OTHER USES OR DISCLOSURES OF YOUR HEALTH INFORMATION**

1. We will obtain your written authorization for: (1) most uses and disclosures of psychotherapy notes (as defined by HIPAA); (2) uses and disclosures of your health information

for marketing purposes; and (3) disclosures that constitute a sale of your health information. We will obtain your written authorization prior to making any use or disclosure other than those described above.

2. A written authorization is designed to inform you of a specific use or disclosure, other than those set forth above, that we plan to make of your health information. The authorization describes the particular health information to be used or disclosed and the purpose of the use or disclosure. Where applicable, the written authorization will also specify the name of the person to whom we are disclosing the health information. The authorization will also contain an expiration date or event.

3. You may revoke a written authorization previously given by you at any time but you must do so in writing. If you revoke your authorization, we will no longer use or disclose your health information for the purposes specified in that authorization except where we have already taken actions in reliance on your authorization.

## V. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information. These rights may be exercised by submitting a request to the Agency. At your request, the Agency will supply you with the appropriate form to complete:

1. **Right to Request Restrictions.** You have the right to request that we restrict the way we use or disclose your health information for treatment, payment or health care operations. However, we are not required to agree to the restriction. If we do agree to a restriction, we will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your treatment. However, if you paid out-of-pocket in full for a health care item or service, and you do not want us to disclose health information about that item or service to your health plan for purposes of payment or health care operations, we must comply with your request.

2. **Right to Request Confidential Communications.** You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number. We will accommodate your reasonable requests.

3. **Right of Access to Personal Health Information.** Upon written request, you have the right to inspect and obtain a copy of your clinical and billing records and other written information that may be used to make decisions about your care (“your designated record set”), except under certain limited circumstances. Under Connecticut law, if The Children’s Center of Hamden, Inc. makes a paper copy of the requested information, we will not charge more than .45 per page, plus postage. No fee will be charged if the medical record is required for a Social Security claim or appeal or for Worker’s Compensation reports. To the extent that we maintain one or more of your designated record sets electronically, you also have the right to receive an electronic copy of such information. You may also direct us to send a copy directly to a third-party designated by you. We may charge a fee, consistent with applicable law, for our costs in responding to your request.

- We may deny your request to inspect or receive copies in certain limited circumstances. If you are denied access to health information, in some cases you will have a right to request review of the denial. This review would be performed by a licensed health care

professional designated by The Children’s Center of Hamden, Inc. who did not participate in the decision to deny access.

4. **Right to Request Amendment.** You have the right to request that we amend your health information. Your request must be made in writing and must state the reason for the requested amendment. We may deny your request for amendment if the information: (a) was not created by us, unless you provide reasonable information that the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by us; (c) is information to which you do not have a right of access; or (d) is already accurate and complete, as determined by us.

- If we deny your request for amendment, we will give you a written denial notice, including the reasons for the denial. In that event, you have the right to submit a written statement disagreeing with the denial. Your letter of disagreement will be attached to your medical record.

5. **Right to an Accounting of Disclosures.** You have the right to request an “accounting” of certain disclosures of your health information. This is a listing of disclosures made by us or by others on our behalf, but does not include disclosures for treatment, payment and health care operations or certain other exceptions.

- You must submit your request in writing and you must state the time period for which you would like the accounting. The time period must be within 6 years from the date of your request. The accounting will include the disclosure date; the name of the person or entity that received the information and address, if known; a brief description of the information disclosed; and a brief statement of the purpose of the disclosure. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs for completing the accounting.

6. **Right to a Paper Copy of This Notice.** You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. In addition, you may obtain a copy of this Notice at our website, [www.tccoh.org](http://www.tccoh.org).

## **VI. SPECIAL RULES REGARDING DISCLOSURE OF PSYCHIATRIC, SUBSTANCE ABUSE AND HIV-RELATED INFORMATION**

For disclosures concerning health information relating to care for psychiatric conditions, substance abuse or HIV-related information, special restrictions may apply. We may not disclose this information without your specific written permission, except as specifically required or permitted by Connecticut or federal law. For example, we generally may not disclose this specially protected information in response to a subpoena, warrant or other legal process unless you sign a special authorization or a court orders the disclosure. A general authorization to release your health information will not be sufficient for purposes of disclosing psychiatric, substance abuse or HIV-related information.

The following are examples of disclosures that may be made without your specific written permission:

- **Psychiatric Information.** We may disclose psychiatric information to a mental health program if needed for your diagnosis or treatment. We may also disclose very limited psychiatric information for payment purposes.

- **HIV-related information.** We may disclose HIV-related information for purposes of treatment or payment.

- Substance abuse treatment. In an emergency, we may disclose information concerning your treatment in a substance abuse program.

## **VII. COMPLAINTS**

1. If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Room 509 F, HHH Building, Washington D.C. 20201.
2. To file a complaint with us, you should contact:  
Sarah Lockery  
The Children's Center of Hamden, Inc  
1400 Whitney Ave, Hamden CT 06517  
(203)248-2116, ext 283  
slockery@tccoh.org
3. We will not retaliate against you in any way for filing a complaint against The Children's Center of Hamden.

**THE CHILDREN'S CENTER OF HAMDEN, INC**  
**Written Acknowledgement of Receipt of Notice of Privacy Practices**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I have received a copy of the Notice of Privacy Practices and understand that if I have further questions or complaints I may contact: The Children's Center of Hamden's Privacy Officer: Sarah Lockery (203) 248-2116, ext 283.

I also understand that I am entitled to receive updates upon request if The Children's Center of Hamden's Notice of Privacy Practices is amended or changed in a material way.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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**To be completed by The Children's Center of Hamden if unable to obtain  
written acknowledgement from client and/or guardian**

On \_\_\_\_\_, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named client's guardian, but was unable to because:

- Guardian declined to sign this Written Acknowledgement.
- Guardian did not understand the request to sign the Written Acknowledgement.
- Other [specify]:

For youth 14 years of age or older serviced by New Choices or Wakeman Hall Outpatient:  
On \_\_\_\_\_, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named client, but was unable to because:

- Client declined to sign this Written Acknowledgement.
- Client did not understand the request to sign the Written Acknowledgement.
- Other [specify]:

\_\_\_\_\_  
Name of Employee

\_\_\_\_\_  
Title of Employee

\_\_\_\_\_  
Date