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.

The Resource Center for Independent Living, Inc. (RCIL), the Learning Disability Association of the Mohawk Valley (LDAMV) and At Home Independent Care, Inc. (AHIC), hereinafter referred to as the Agency respect you and your privacy. We are committed to keeping all information received or created confidential.

We want you to have a clear understanding of how we use and safeguard information about you. This Notice of Privacy Practices describes how we may use and disclose your protected health information in order to carry out services, payment and for other purposes permitted or required by law. It also describes your rights to access and control your information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of the legal duties and privacy practices with respect to your protected health information and to provide you notification when a breach of unsecured protected health information occurs.

Health information means any information, whether oral or recorded in any form, that is created or received by the Agency, relates to the past, present or future physical, mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

How Your Protected Health Information May Be Used or Disclosed

The Agency uses protected health information about you for services, payment and regular health care operation purposes. We do not require authorization to use your protected health information for these purposes.

Services: Providing you with care and services related to your health, such as working with other agencies involved with the delivery of services. RCIL and LDAMV are members of the Oneida County Mental Health Network and HealtheConnections may exchange information for the purposes of coordinating services.

Payment: Information needed for billing, insurance, or compensation for services, if necessary. We may provide necessary portions of your protected health information to our billing department and to your health plan to get paid/reimbursed for the services we provide to you.

Regular Health Care Operations: Activities that may include quality assessment, program evaluation, investigating and auditing.

Emergency Care: To help you obtain treatment in a medical emergency. An authorization is required as soon as reasonably possible after the emergency and the provider should document the reasons as to why the authorization could not be received.

When Legally Necessary: If required by federal, state or local law. We may make disclosures when a law requires that we report information to government agencies or law enforcement personnel about victims of abuse, neglect, domestic violence or to avoid serious threat to health or safety of a person or the public.

National Priorities: Public health authorities authorized by law to collect or receive information for preventing or controlling disease, injury or disability and to public health or other governmental agencies authorized to receive reports of child abuse and neglect, or other National security activities authorized by law.

Public Safety: The agency may disclose any PHI that is perceived to be necessary to "prevent" or lessen a serious and imminent threat to a person or the public when it is perceived this will lessen or prevent the threat.

We may provide protected health information to a family member, friend or other person that you indicate is involved in your services or the payment for your services **unless you object, in whole or in part**. The opportunity to consent may be obtained retroactively in emergency situations.

ALL OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION.

IN ADDITION, ANY ALCOHOL OR SUBSTANCE ABUSE RECORDS ARE PROTECTED UNDER FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY. (42CFR Part II)
ANY HIV RECORDS ARE PROTECTED UNDER PUBLIC HEALTH LAW GOVERNING CONFIDENTIALITY. (Article 27-F)

When The Agency May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights
You have the right to obtain and review a copy of your protected health information. The agency may request this be in a written statement.

You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the requested restriction.

You have a right to request that we amend your health information. An amendment can only be granted if the information requested to be amended is created by the Agency.

You have a right to receive an accounting of disclosures of your health information. This will not include any dates before April 14, 2003 and cannot be longer than six years from the date of the request.

You have a right to receive confidential communications of protected health information and the manner in which it is sent to you. Within reason, you have the right to ask that we send information to you at an alternate address (such as requesting that we send information to your work address rather than your home address) or by alternate means (such as by regular mail versus e-mail, if such methods are reasonably available).

You have a right to inspect and obtain a paper copy of this Notice of Privacy Practices. You will be asked to sign an Acknowledgement of Receipt of this Notice.

You have a right to complain to the agency if you are dissatisfied with the services you are receiving. You have a right to complain to the agency and (HHS) Health and Human Services if you believe your privacy rights have been violated. You will not be punished in any way for filing a complaint. (Please refer to our Complaint Form for information regarding internal and/or external complaints.)

The Agency will provide you with any or all of the form(s) upon your request.

Changes to this Notice of Privacy Practices
We are bound by the terms of this notice currently in effect and reserve the right to amend this Notice of Privacy Practices at any time in the future. If such amendment is made, all individuals currently active in our programs will be provided a revised Notice of Privacy Practices by mail or at their next scheduled meeting.

If you have any questions regarding this notice or need further information please contact the Compliance Department at (315) 797-4642, extension. 2904 or by writing to RCIL, attention Compliance Department, RCIL, P.O. Box 210, Utica, NY 13503-0210.

RCIL Utica Office 409 Columbia St. P.O. Box 210 Utica, NY 13503-0210 Voice (315) 797-4642 Fax (315) 797-4747	**RCIL Herkimer Office** Steuben Center 401 E. German St. Herkimer, NY 13350 Voice (315) 866-7245 Fax (315) 866-7280
AHIC Utica Office 409 Columbia St. P.O. Box 210 Utica, NY 13503-0210 Voice (315) 797-4642 Fax (315) 738-2703	**RCIL Amsterdam Office** 347 West Main St. Amsterdam, NY 12010 Voice (518) 842-3561 Fax (518) 842-0905
LDAMV Utica Office 401 Columbia St. Utica, NY 13502 Voice (315) 797-1253 Fax (315) 797-4006	**LDAMV North Country Office** 146L Arsenal Street Suite 10A Watertown, NY 13601 Voice (315) 785-9440 Fax (315) 786-1205
RCIL Website: http://www.rcil.com	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Agency's Notice of Privacy Practices and understand my rights and responsibilities as explained in them. **Please initial both statements below.**

____ I acknowledge that the Agency may disclose my protected health information in order to provide services, receive payment and/or funding for services, for regular health care operations or in an emergency situation or in other situations as described in the Notice of Privacy Practices I have received.

____ I understand I may request access to my protected health information; request restrictions on disclosure; request amendments to my protected health information; I can choose how my protected health information is sent and to where; I can find out where my information has been disclosed; and I may make a complaint if I'm dissatisfied with the services I am receiving or if I feel my privacy rights have been violated.

IN ADDITION, I UNDERSTAND THAT ANY ALCOHOL OR SUBSTANCE ABUSE RECORDS ARE PROTECTED UNDER FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY. (42 CFR PART II)
ANY HIV RECORDS ARE PROTECTED UNDER PUBLIC HEALTH LAW GOVERNING CONFIDENTIALITY. (ARTICLE 27-F)

Signature of Participant:

_____

Please Print Name Signature Date

OR:

Signature of Participant's Representative / Guardian
(required if participant is not the guardian**):**

_____

Please Print Name Signature Relationship Date

Signature of Interpreter: (only if applicable**)**

_____

Please Print Name Signature Date