

THE FELLOWSHIP HOUSE
NOTICE OF PRIVACY PRACTICES
AND PATIENT RIGHTS

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.

Effective Date: April 14, 2003 and modifications as of September 22, 2013.

We respect patient/client confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by this Agency.

Privacy Contact. If you have any questions about this policy or your rights contact Mickey Finch, Chief Executive Officer, at (618) 833-4456.

In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond our Agency. This includes for:

Treatment. We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our Agency that we are consulting with or referring you to.

Payment. With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes. You have a right to restrict certain disclosures of your protected health information if you pay out of pocket in full for the services provided to you.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We may be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may send a letter or leave appointment information on your voice mail or leave an email or text message unless you tell us not to.

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As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse. A U.S. Marshall warrant for your arrest supercedes any confidentiality.

Coroners. We are required to disclose information about the circumstances of your death to a coroner who is investigating it.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. We are also required to share information, if requested with the U.S. Department of Health and Human Services to determine our compliance with federal laws related to health care and to Illinois state agencies that fund our services or for coordination of your care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

Fundraising/Marketing. As a not-for-profit provider of health care services we need assistance in raising money to carry out our mission. We may contact you to seek a donation. You will have the opportunity to opt out of receiving such communication. You may also opt out of our providing your contact information for any marketing that results in compensation to the Agency.

PATIENT RIGHTS

You have the following rights under Illinois and federal law.

Copy of Record. You are entitled to inspect the client record our Agency has generated about you. We may charge you a reasonable fee for copying and mailing your record.

The Fellowship House fee schedule for medical records is as follows:

First 25 pages	\$ 0.99 per page
Pages 26-50	\$ 0.66 per page
Pages 51+	\$ 0.33 per page
Handling Fee	\$26.38 per request

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Release of Records. You may consent in writing to the release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization. Except as described in this Notice or as required by Illinois or Federal law, we cannot release your protected health information without your written consent.

Restriction on Record. You may ask us not to use or disclose part of the clinical information. This request must be in writing. The Agency is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the **Privacy Contact**.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that payment information you are providing is correct.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the **Privacy Contact** and ask for the *Request to Amend Health Information* form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years, please submit your request in writing to our **Privacy Contact**. We will notify you of the cost involved in preparing this list.

Notification of Breach. You have a right to be notified if there is a breach of your unsecured protected health information. This would include information that could lead to identity theft. You will be notified if there is a breach or a violation of the HIPAA Privacy Rule and there is an assessment that your protected health information may be compromised.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our **Privacy Contact** in writing at our office for further information. You may also contact the Secretary of U.S. Department of Health and Human Services if you believe our Agency has violated your privacy rights. We will not retaliate against you for filing a complaint.

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Changes in Policy. The Agency reserves the right to change its Privacy Policy based on the needs of the Agency and changes in state and federal law.

PATIENT RIGHTS STATEMENT

As a patient of our Agency you have the following rights:

1. To not be denied services on the basis of age, sex, race, religious beliefs, ethnic origin, marital status, physical or mental disability, sexual orientation, HIV status, or criminal record.
2. To services provided in the least restrictive environment available for your needs pursuant to an individualized treatment plan. You will have nondiscriminatory access to services in accordance with the American's With Disabilities Act.
3. Confidentiality of your status and records, including HIV status and testing as provided for under Illinois law.
4. Our Agency has the right to limit services based on the funding we receive. This may require us to prioritize services based on the severity of your service needs. Services not covered by governmental grants are charged based on the cost of providing those services.
5. No patient shall be presumed legally disabled unless declared so by a court.
6. You have the right to give an informed consent to treatment. You also have a right to refuse treatment and be told the consequences of such refusal. This could include the Agency being unable to provide services to you.
7. If you believe your rights have been violated you have a right to contact the following agency:
Illinois Department of Human Services
Division of Alcoholism and Substance Abuse
100 West Randolph Street, Suite 5-600
Chicago, IL 60601
(312) 814-3840
8. If you have a complaint about the services provided, you may file a letter of grievance and submit the grievance to the Privacy Contact.