



## Notice of Privacy Practices

*Effective January 7, 2008*

**This Notice describes how Medical Information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how Agor Behavioral Health Services, Inc. may use and disclose your PHI in accordance with applicable law and the ACA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Agor Behavioral Health Services, Inc. is required to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. Agor Behavioral Health Services, Inc. is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. Agor Behavioral Health Services, Inc. will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

### **How Agor Behavioral Health Services, Inc. may use and disclose Health Information about you.**

**For Treatment:** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment:** We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations:** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. We may use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

**Required by Law:** Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.



**Without Authorization:** Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations (such as the social work licensing board or the health department).
- Required by Court Order.
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Verbal Permission:** We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization:** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

## Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Agor Behavioral Health Services, Inc. at 24402 West Lockport Street, Suite 204, Plainfield, Illinois, 60544:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI Agor Behavioral Health Services, Inc. have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

## Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Agor Behavioral Health Services, Inc. at 24402 West Lockport Street, Suite 204, Plainfield, Illinois, 60544 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is January 7, 2008.



## Notice of Privacy Practices Receipt and Acknowledgment of Notice

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Agor Behavioral Health Services, Inc. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Agor Behavioral Health Services, Inc. at 630-621-5824 or at [dragor@doctoragor.com](mailto:dragor@doctoragor.com).

Client Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent, Guardian or Personal Representative Signature\*:

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*\*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)*

\_\_\_\_\_ Client Refuses to Acknowledge Receipt

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Authorization for Release of Confidential Health Information

I, \_\_\_\_\_, hereby authorize Agor Behavioral Health Services, Inc.
(Name of Client or Authorized Agent)
to release to/or secure from

\_\_\_\_\_
(Name of Health Care Facility, Physician, Agency etc.)

\_\_\_\_\_
(Street Address, City, State and Zip Code)

the following information contained in the client record of

\_\_\_\_\_ Born: \_\_\_/\_\_\_/\_\_\_
(Client's Name) (Birth date)

To be disclosed, the following items must specifically be checked:

- O Account Information O Treatment Summary
O Office Psychotherapy Notes O Verbal Discussion of Case
O Psychological Testing Report O Other (specify): \_\_\_\_\_

The purpose(s) of the authorization is (are):

- O At the request of the individual O Coordination of Mental Health Treatment
O Payment of Account O Other (specify): \_\_\_\_\_

I understand that the practice may not condition treatment on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be subject to
redislosure by the recipient and may no longer be protected by law.
I understand that I may be responsible for the cost of medical record copying service.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving written notice to the
practice of my desire to do so. I also understand that I will not be able to revoke this authorization
in cases where the therapist has already relied on it to use or disclose my health information.
Written revocation must be sent to the practice. Absent such written revocation, this Authorization
for Release of Confidential Health Information will terminate on \_\_\_\_\_.

(Date)

Date: \_\_\_/\_\_\_/\_\_\_

Signature of Client\*\*

Signature of Witness

Signature of Parent or Guardian

\*\*Client signature is required in addition to the parent or guardian signature for clients ages 12-17.