



# TUSCOLA BEHAVIORAL HEALTH SYSTEMS

## *Health Insurance Portability and Accountability Act (HIPAA)*

### *Notice of Privacy Rights*



**TUSCOLA**  
*Behavioral Health Systems*  
A Michigan Community Mental Health Authority

***323 N. State St., Caro, MI 48723***

***989.673.6191 or 800.462.6814***

***TDD: 866.835.4186***

***www.tbhsonline.com***

# Tuscola Behavioral Health Systems

## HIPAA NOTICE OF PRIVACY PRACTICES

### For Tuscola Behavioral Health Systems

(referred to in this document as “the Agency”)

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. PLEASE NOTE THAT THIS NOTICE IS SEPARATE FROM THE NOTICE YOU HAVE RECEIVED RELATIVE TO YOUR RIGHTS UNDER THE MICHIGAN MENTAL HEALTH CODE.

#### I. Uses and Disclosures of Protected Health Information:

The Agency may use or disclose your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the Agency has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Rule or State law. Note that the Agency may be required under Michigan law to obtain consent from you in connection with certain disclosures that fall within the listed below categories;

**Treatment** We will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription or to a subcontracted provider who is also providing services for you. We may also disclose protected health information to physicians who may be treating you or consulting with the Agency with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

**Payment** Your protected health information will be used and disclosed, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurer to get approval for the treatment that we recommend. For example, if a certain level of service is recommended, we may need to disclose information to your health insurer to get prior approval for the level of service you need. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services or to demonstrate that required documentation exists. We may also disclose patient information to another provider involved in your care for the other provider’s payment activities.

**Operations** We may use or disclose your protected health information, as necessary, for our own health care operations in order to facilitate the function of the Agency and to provide quality care to all consumers. Health care operations include such activities as:

- Quality assessment and improvement activities.
- Employee review activities.
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision.
- Accreditation, certification, licensing or credentialing activities.

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- Review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs.
- Business management and general administrative activities.

In certain situations, we may also disclose consumer information to another provider or health plan for their health care operations.

**Other Uses and Disclosures** As part of treatment, payment and healthcare operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment including the use of post cards and/ or messages left on answering machines. \*
- To inform you of potential treatment alternatives or options. \*
- To inform you of health-related benefits or services that may be of interest to you. \*

**\*Unless you indicate that you would prefer not to be contacted in that manner.**

## **II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object:**

The HIPAA Privacy Rule also allows us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

**When Legally Required** We will disclose your protected health information when we are required to do so by any Federal, State or local law.

**When There Are Risks to Public Health** We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

**To Report Abuse, Neglect Or Domestic Violence** We may notify government authorities if we believe that a consumer is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the consumer agrees to the disclosure.

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**To Conduct Health Oversight Activities** We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

**In Connection With Judicial And Administrative Proceedings** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a signed authorization (in a format approved by the Michigan Court Administrator).

**For Law Enforcement Purposes** We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the Agency has a suspicion that your death was the result of criminal conduct.
- In an emergency in order to report a crime.

**To Coroners, Funeral Directors, and for Organ Donation** We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**For Research Purposes** We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

**In the Event of A Serious Threat To Health Or Safety** We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**HIPAA**

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**For Specified Government Functions** In certain circumstances, the Federal regulations authorize the Agency to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

**For Worker's Compensation** The Agency may release your health information to comply with worker's compensation laws or similar programs.

### **III. Uses and Disclosures Permitted Without Authorization But With Opportunity to Object:**

Although HIPAA does not require that we obtain a written HIPAA authorization for disclosures made to family members in certain circumstances, Michigan law requires that we obtain your written consent prior to disclosing your health information to a family member who is not your personal representative. The Agency will continue to follow its current policy to obtain written consent under State law when disclosing patient information to a family member or friend who is not a personal representative of the patient.

### **IV. Uses and Disclosures That You Authorize:**

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

### **V. Your Rights:**

In addition to other rights you may have under State law, such as the rights you have under Michigan Mental Health Code, you have the following rights under HIPAA regarding your health information:

**The right to inspect and copy your protected health information** You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. You may request a copy of your protected health information in any form you choose (e.g. paper, electronic, etc.) provided it is readily producible. If you request and sign in writing, a copy of your protected health information can be provided to another clearly designated individual, including where to send the copy of the protected health information. Subject to limitations imposed upon us by MCL 330.1748 (4) of the Michigan Mental Health Code, under Federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information.

Depending on the circumstances, you may have the right to have a decision to deny access reviewed. We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision. To inspect and copy your health information, you must submit a written request to the Privacy Officer whose contact information is listed on the last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Please contact our Privacy Officer if you have questions about access to your health record.

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**The right to request a restriction on uses and disclosures of your protected health information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. Your request must state the specific restriction requested and to whom you want the restriction to apply. The Agency is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the Agency does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

**The right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

**The right to request amendments to your protected health information.** You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. For example, if we believe that the information is correct as is. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

**The right to receive an accounting** For accountings that we are required to make under HIPAA you have the right to request an accounting of certain disclosures of your protected health information made by the Agency. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

**The right to obtain a paper copy of this notice** Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice.

**The right to opt out of fundraising communications** The Agency may use certain protected health information for the purpose of fundraising communications to you. You may choose to opt out of subsequent fundraising communication by informing the Agency. You may also choose to opt back in to future fundraising communication by informing the Agency.

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**The right to restrict certain disclosures of protected health information to health plans** If you request, we must restrict disclosure of your protected health information to your health plan if you or someone other than this Agency has paid for those services in full.

**The right to be notified if your protected health information is affected by a security breach** In the event of a breach of unsecured protected health information, the Agency must provide notification of the breach to the affected individual, the United States Government and in certain circumstances, the media.

## **VI. Our Duties:**

The Agency is required by law to maintain the privacy of your health information and to provide you with this Notice. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain.

## **VII. Complaints:**

You have the right to express complaints to the Agency and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the Agency by contacting the Agency's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

## **VIII. Contact Person:**

The Agency's contact person for all issues regarding patient privacy and your rights under HIPAA is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. Complaints against the Agency, can be mailed to the Privacy Officer by sending it to:

**Tuscola Behavioral Health Systems  
323 N. State St., Caro, MI 48723  
ATTN: Privacy Officer**

The Privacy Officer can be contacted by telephone at:

**989.673.6191 or 1.800.462.6814**

**IX. Effective Date** This Notice is effective November 2013.

*Please detach and sign the next page.*

*By doing so you acknowledge that you have received the HIPAA information.*



# Tuscola Behavioral Health Systems

## ***SUMMARY PRIVACY RIGHTS***

### ***of Health Insurance Portability and Accountability Act (HIPAA)***

HIPAA is a law that protects your privacy. We are required to inform you of your rights under this law. This document is a short summary of your rights. A longer version with more information is attached. If you have questions you may ask to speak to our Privacy Officer.

- We will use or share your private information with others as necessary for treatment. We may also use or share your information to get paid for our services and to run our agency.
- You have a right to know if your protected health information is ever affected by a security breach. In the unlikely event this happens, you will be directly notified.
- We may remind you of your appointment by sending a postcard or leaving a message on your answering machine. You may ask us not to do these things.
- If we need to share your information for other reasons, we will ask you to sign a special form. If you change your mind and tell us, we will stop sharing the information.
- You have the right to see the information we have about you and to get copies of that information in any format you choose (paper, electronic, etc.). If we refuse your request we must tell you the reason.
- If you think that the information you saw is wrong, you can write to us and ask us to change it. We do not have to agree to change the information. If we do not agree we have to tell you why.
- You can get a list of the people we have shared your information with. If we shared the information to treat you, to receive payment, or to run our agency, it will not be on the list.
- You can ask us not to use your information in a certain way. You may also ask us not to share your private information with certain people. In some cases, as stated in the Michigan Mental Health Code, we may not agree to these requests.
- You can ask that we send your mail to a certain address or that we only call you at a certain time or place.
- You have the right to complain to our Privacy Officer if you think that we did not follow these rules.

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## ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY RIGHTS

### *Acknowledgement:*

*I acknowledge that I have received the attached HIPAA Notice of  
Privacy Rights.*

\_\_\_\_\_  
*Consumer Name (PLEASE PRINT)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Consumer Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Personal Representative Signature  
(if required)*

\_\_\_\_\_  
*Date*

*If Personal Representative's signature appears above, please describe Personal Representative's  
relationship to the Consumer: (Please circle)*

*Legal guardian*

*Parent of minor child*

**HIPAA**

*Programs and services are supported and funded, in part, by the Michigan Department of Community Mental Health.*

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