CoveCare Center® | COUNSELING THAT EMPOWERS CHANGE

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. If you have any questions about this notice, please contact our Privacy Officer at 845-225-2700, x 159.

WE ARE COMMITTED TO YOUR PRIVACY

At CoveCare Center, we are committed to maintaining the privacy and confidentiality of your health information.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You have the right to:

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request.
- We may charge a reasonable, cost-based fee for either of the above services.

Ask us to amend your medical record.

- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- If we say “no,” you can write a letter that explains your side of the story. We will add that letter to your medical record.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care or our ability to be reimbursed.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we've shared information.
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.
- You can complain if you feel we have violated your rights by contacting us at 845-225-2700, x159 or by sending a letter to Privacy Officer, CoveCare Center, 1808 Route Six, Carmel, NY 10512.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care, if you do not object.
- Share information in a disaster relief situation.

- You can indicate your choices by completing an authorization, commonly referred to as a consent. This is especially important when you're asking us to share information about alcohol/drug treatment, mental health, or confidential HIV/AIDS-related treatment.
- The form enables you to specify individuals or entities with whom you want your information shared and specifically what information to share.
- You have the right to revoke (withdraw) this authorization at any time except when we have already shared your information based on the consent you gave us. You are also not able to revoke your authorization if it was obtained for the purpose of receiving payment from your insurance company.

- You can choose to write a letter specifying the information we can no longer share and the person, organization, facility, or program we should no longer share your information with. You can also use our Revocation of Authorization for Release of Information form on our website.
- Please be as specific as you can in writing your revocation. Please indicate the name and address of the person(s) we are currently sharing this information with and include the date, or approximate date, you signed your authorization. Please address your written request to:

  CoveCare Center
  Medical Records
  1808 Route 6
  Carmel, NY 10512

  Your request won't be effective until we receive it and verify that you have provided the information we need to comply with your revocation request.

- CoveCare Center may condition your treatment on your refusal to sign this consent.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we won't share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again and we must comply with your request.

OUR USES AND DISCLOSURES

We typically use or share your health information for treatment, payment, and healthcare operations.

Treat You.

We can use your health information and share it with other professionals who are treating you.

Examples:

- *A doctor treating you asks another doctor about your overall health condition.*
- *We share information with a pharmacy that is filling your prescription.*

Bill for your services.

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

Run our organization.

We can use and share your health information to run our business operations and the operations of our related treatment entities.

Example: We use health information about you to manage your treatment and services.

WE USE OR SHARE YOUR HEALTH INFORMATION TO CONTRIBUTE TO THE PUBLIC GOOD

We are allowed or required to share your information in other ways. Many of these contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues.

We can share health information about you for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

Do research.

We can use or share your information for health research.

Comply with the law.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests.

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director.

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests.

We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions.

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

WE SHARE YOUR INFORMATION TO ANALYZE OUR DATA AND IMPROVE SERVICES TO OUR CLIENTS

We will share your Protected Health Information with third party "business associates" that perform various activities for the agency. Whenever an arrangement between Covecare Center and a business associate involves the use or disclosure of your Protected Health Information, we will have a written contract that contains terms that will protect the privacy of your Protected Health Information.

Your Protected Health Information may be accessed by participating providers in the Coordinated Behavioral Health Services Independent Practice Association (*cbhsinc.org)* when the participating providers have a treating relationship with you.

OUR RESPONSILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and offer you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For More Information See:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Revised 1/1/2022

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the CoveCare Center's Notice of Privacy Practices.

_____ _____

Client Name (Print) Client Signature

If completed by a client's personal representative, please print and sign your name in the space below

_____ _____

Personal Representative (Print) Personal Representative's Signature
Relationship

For CoveCare Center use only

Complete this section if this form is not signed and dated by the client or client's personal representative.

I have made a good-faith effort to obtain a written acknowledgement of receipt of the CoveCare CenterNotice of Privacy Practices but was unable to for the following reason:

☐ Client refused to sign
☐ Client unable to sign
☐ Other

_____ _____

Employee Name Date

This form should be placed in the client's medical record

Revised 3/29/2019

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PERMISSION TO TREAT A MINOR

Childs Name: _____ DOB: _____

I am the custodial parent/legal guardian of the above named child. I give permission for any of the CoveCare Center professional staff to provide psychotherapeutic treatment to _____.

_____

Signature Date

_____

Print Name Relationship

_____

Witness

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

PSYCKES Consent Form
COVECARE CENTER

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is an administrative database maintained by the New York State Office of Mental Health (OMH). It contains health information from the NYS Medicaid claims database, health information from the clinical records of persons who have received care from State operated psychiatric centers, and health information from other NYS health databases. This administrative data includes identifying information (such as name, date of birth), information about health services that have been paid for by Medicaid, and information about a person's health care history (such as treatment for illnesses or injuries a person has had, test results, and lists of medication a person has taken). For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

The health information in PSYCKES can help your provider provide you with good care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I give consent"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I deny consent"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," this does not mean your provider is completely barred from accessing your medical information in any way. For example, if the Medicaid program has a quality concern about your healthcare, then under federal and state regulations your provider may be given access to your data to address the quality concern. There are also exceptions to the confidentiality laws that may permit your provider to obtain necessary information directly from another provider for treatment purposes under state and federal laws and regulations.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

☐ **I give consent for this provider to access all** of my electronic health information that is in PSYCKES in connection with providing me any health care services.

☐ **I deny consent for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative	Date

Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Signature of Witness	Print Name of Witness

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Will be Used.** Your electronic health information will be used **only** to:
    - Provide you with medical treatment and related services
    - Evaluate and improve the quality of medical care provided to all patients.

Note: The choice you make in this Consent Form does not allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You Are Included?** If you give consent _____ may access all of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES includes information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
    - Mental health conditions
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Sexually transmitted diseases

3. **Where Health Information About You in PSYCKES Comes From.** If you received health related services that were paid for by Medicaid, information about those services will be stored in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be stored in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. Health information from other databases maintained by NYS is also included in PSYCKES. New health database may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on_____'s medical staff who are involved in your medical care; health care providers who are covering or on call for _____'s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call_____at_____; or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by_____ _____to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

7. **Effective Period.** This Consent Form will remain in effect until 3 years after the last date you received any medical services from _____, or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to _____. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling _____ _____ at _____. Note: Organizations that access your health information through_____while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.

Revised 6.26.2015