The Briarwood Clinic

3645 N Briarwood Ln Ste A Muncie, IN 47304
Ph: (765) 289-5520 Fax: (765) 289-5840

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all health records and other individually identifiable health information used or disclosed by us in any form be kept confidential.

This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, obtain payment, maintain health care operations, and for other purposes permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you including demographics, diagnosis, treatment plan and goal, and mental health history that may identify you and relate to your past, present or future physical or mental health, condition, and related health care services.

Uses and Disclosures of PHI: Your PHI may be used and disclosed for the purpose of providing health care services to you, your dependents or others for whom you've obtained or sought care, to obtain payment for your health care services, to support the operation of this office, to obtain insurance benefits and authorization for treatment, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your mental health care and related services. This includes coordination or management of your health care with third parties such as, primary care physicians, home health agencies, insurance companies, employee assistance programs, law enforcement officials, judicial entities, or other parties involved in providing care to you.

Payment: Your PHI will be used as needed to obtain payment for our health care services. This may include the release of kept and missed appointments and the associated charges.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities of the office, including but not limited to, quality assessment activities, employee review, training of students, licensing of providers, conducting or arranging for any other business activities required to provide care including, but not limited to, contacting you by telephone, email or standard mail to confirm, reschedule, cancel or bill appointments.

We will only use or disclose your PHI in the following situations without your consent: as required by law, public health issues required, such as: communicable diseases, health care oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, criminal activity, military activity, national security, workers comp, inmates, required uses and disclosures under law. We must make disclosures to you, and when required by the Secretary of Department of Health and Human Services to investigate or determine our compliance with the requirements of sections 164.500.

Other permitted and required uses and disclosures will be made only with your consent, or with the opportunity to object, unless required by law. You may revoke this authorization at any time in writing, except to the extent your therapist or the clinic has taken an action in reliance on the use of disclosure indicated in the authorization previously given.

Your Rights With Respect to PHI: You have the right to inspect and receive a copy your PHI. Under federal law, however, you may not inspect or obtain a copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and PHI that is subject to law that prohibits access to PHI. We may choose to assess a fee for reproduction or submission of PHI. This fee will not exceed the allowable amount as set forth by Indiana Law 760 IAC 1-71 which states:

$1.00 per page for pages 1-10
$0.50 per page for pages 11-50
$0.25 per page for pages 51 and higher
OR
$20 labor fee for pages 1-10
$0.50 per page for pages 11-50
$0.25 per page for pages 51 and higher

Provider or clinic may charge the actual cost of mailing the PHI. Provider or clinic may charge an additional $1O if the request is for copies to be provided within two working days, only if the provider/clinic chooses to honor this request. Provider or clinic may charge an additional fee of $20 for certifying a patient's PHI.

A request to inspect or receive a copy of PHI must be submitted in writing and must be accompanied by proof of the right to receive such PHI, such as: picture identification, signature for comparison to original on file, custodial documentation clearly stating parental, guardian, or power of attorney rights to obtain PHI. We reserve the right to thoroughly investigate any request which we believe to be inaccurate, false or detrimental to the care or well-being of our patient. In such an event, we will notify you of our need to investigate to obtain accurate proof and documentation. Upon verification and confirmation of your right to obtain PHI, we will release the requested PHI within 30 days, not including weekends, holidays, or days when the clinic is not in operation.

You have the right to **request** a restriction of PHI. This means you may ask us not to use or disclose any part of your PHI for purposes of treatment, payment, or healthcare operations. You may also **request** any part of your PHI not be disclosed to family members or friends who may be involved in your care, or for the specific restriction requested; and to whom you want the restriction to apply. The clinic and/or therapist will notify all parties involved to ensure the request has been noted.

The clinic and/or therapist is not required to agree to a restriction you request. If the clinic and/or therapist believes it is in your best interest to permit use and disclosure of PHI, the restriction will not be granted. However, you will be notified that such a decision has been made. You have the right to terminate care with your therapist and seek another healthcare professional.

You have the right to a paper copy of the Privacy Act Policy notice, upon **request** even if you have agreed to accept this notice alternatively.

You have the right to request your therapist amend your PHI. If we deny your request of amendment you have the right to file a statement of disagreement with us to become a part of your PHI records, and we may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal***. In such an event, we respectfully request that you inform the clinic and/or your therapist of any request, concern or complaint so that we may attempt to rectify it before you file a formal complaint with another agency.***

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you through public posting, or by mail, of any changes. You have the right to object or withdraw from treatment as provided in this notice.

You have recourse if you feel your privacy protection has been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, and violations of the provisions of this notice or the policies and procedures of our office.
We will not retaliate against you for filing a complaint.

Please contact us for more information:

The Briarwood Clinic
Rachel L. Smith, Director
3645 North Briarwood Lane Suite A
Muncie, IN 47304
(765) 289-5520

For more about HIPAA , or to file a complaint:

Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Ave., Suite 240
Chicago, IL 6060 I
(312) 886-2359