TIDES FAMILY SERVICES
NOTICE OF PRIVACY PRACTICES

I. 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.

II. [I/WE] HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION ("PHI").

This notice explains how [I/we] use and disclose your protected health information ("PHI" for short). [I am/We are] required by law to protect the privacy of PHI, and to provide you with this notice and follow the privacy practices described in it.

PHI includes information that [I/we] create or receive about your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment for health care provided to you.

[I/We] may change the terms of this notice and [my/our] privacy practices at any time. Any change [I/we] make will apply to the PHI [I/we] already have as well as to any new PHI [I/we] create or receive. When [I/we] change [my/our] practices, [I/we] will promptly change this notice and post it in the main reception area of [my/our] office [and on [my/our] web site at: www.tidesfs.org.

III. HOW [I/WE] MAY USE AND DISCLOSE YOUR PHI.

[I/We] use and disclose PHI for many different reasons. Below, [I/we] describe the different reasons and give you some examples.

A. Use and Disclosure of PHI for Treatment, Payment, or Health Care Operations. [I/We] may use and disclose PHI for the following reasons:

1. For treatment. [I/We] may use and disclose PHI in order to provide therapy, counseling, treatment, and other services to you. For example, [I/We] may use and disclose PHI about you to consult with other professionals about your care. [I/We] will obtain your consent before disclosing your PHI for treatment purposes if state law requires [me/us] to do so.

2. For payment. [I/We] may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. For example, [I/we] may disclose PHI to your health plan to get paid for the health care services provided to you. [I/We] may also disclose PHI to billing companies and companies that process [my/our] health care insurance claims. [I/We] will obtain your consent before disclosing your PHI for payment purposes if state law requires [me/us] to do so.

3. For health care operations. [I/We] may use and disclose PHI in order to operate this [practice/agency]. For example, [I/we] may use PHI in order to evaluate the quality of services that you receive. [I/We] may also disclose PHI to [my/our] accountants, attorneys, and others in order to make sure [I am/we are] complying with the laws that affect [me/us]. [I/We] will obtain your consent before disclosing your PHI for the purposes of [my/our] health care operations if state law requires [me/us] to do so.

B. Other Uses of PHI. [I/We] may also use and disclose your PHI for the following reasons:

1. Reports required by law. [I/We] may disclose PHI when legally required to do so. For example, [I/we] may use PHI to make mandatory reports to various government agencies about suspected abuse, mistreatment, neglect, or exploitation of vulnerable people such as children and the elderly.

2. Health oversight. [I/We] may disclose your PHI to certain government agencies authorized by law to license, audit, inspect, or investigate health and mental health care providers and the health care system.

3. To avoid harm. Consistent with state law, [I/we] may disclose PHI to the police or other appropriate persons, in order to avoid a serious threat to the health or safety of a client, another person, or the public.

4. Appointment reminders, treatment alternatives, and health-related benefits or services. [I/We] may use PHI to give you appointment reminders; or give you information about treatment choices or other health or mental health care services or benefits [I/we] offer.

5. Legal proceedings. [I/We] may disclose PHI pursuant to a valid court order, search warrant, and, under certain circumstances, in response to a subpoena or other discovery request. [I/We] may also use or disclose PHI to defend against a complaint.

6. As required by law. [I/We] will disclose PHI when required to do so by federal or state law.

7. Fundraising. Unless you object, we may use limited PHI about you to inform you about our fundraising efforts. Donations are used to expand and support the services and educational programs we provide to the community. You may opt out of receiving such fund raising communications at any time by contacting us by phone or in writing at: (401)822-1360, or 215 Washington Street, West Warwick, RI.

C. When [My/Our] Use or Disclosure of PHI Requires Your Prior Written Authorization. [I/We] must ask for your written authorization for any use or disclosure of PHI not described in sections III-A or III-B above not specifically permitted by applicable law, including: most uses and disclosures of psychotherapy notes which are separated from the rest of your clinical record; most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; and disclosure that constitute the sale of PHI. If you authorize [me/us] to use or disclose your PHI, you can later withdraw the authorization and stop any future use or disclosure of your PHI based on it. You can withdraw an authorization by written request to: VP of Treatment Programs, 215 Washington Street, West Warwick, RI.

IV. YOUR RIGHTS REGARDING YOUR PHI.

A. Your Right to Request Limits on [My/Our] Use and Disclosure of PHI. You may ask that [I/we] limit how [I/we] use and disclose your PHI for purposes of treatment, payment, or health care operations. [I/We] will consider your request but [am/are] generally not legally required to agree to it. If [I/we] agree to your request, [I/we] will comply with your limits, except in emergency situations.

[I/We] are required to agree to your request if the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for in full out of pocket. In that case, [I/we] will honor your request for a restriction.

B. Your Right to Choose How [I/We] Send PHI to You. You may ask that [I/we] send information to you at a different address (for example, to your work address rather than your home address) or by different means (for example, by mail instead of telephone). [I/We] will agree to your reasonable request, as long as [I/we] can easily provide the information in the way you request.

[I/We] may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. [I/We] will not ask you for an explanation of why you are making the request.

C. Your Right to View and Get a Copy of Your PHI. You have the right to view or obtain a copy of your PHI. Your request must be in writing. However, there are some circumstances in which [I/we] may deny your request. If [I/we] deny your request, [I/we] will tell you, in writing, [my/our] reason(s) for the denial and explain what appeal rights, if any, you have.

If you request a copy of your PHI, [I/we] may charge a fee for it if permitted to do so by law. Instead of providing the PHI you requested, [I/we] may offer to give you a summary or explanation of the PHI, as long as you agree to it, and to the associated cost, in advance. To view or obtain a copy of your PHI please send your written request to: VP of Treatment Programs, 215 Washington Street, West Warwick, RI.

D. Your Right to a List of the Disclosures of Your PHI that [I/We] Have Made. You have the right to an accounting of instances in which [I/we] disclosed your PHI to others. Some disclosures will not be listed, however. For example, the list will not include disclosures made for the purpose(s) of treatment, payment, or health care operations, or disclosures that you authorized or that were made directly to you.

If you ask for more than one accounting within a twelve-month period, [I/we] may charge you a fee for every accounting provided after the first one. For a list of disclosures you must submit a request to: VP of Treatment Programs, 215 Washington Street, West Warwick, RI.

E. Your Right to Correct or Update Your PHI. If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be in writing and include the reason for the request. Your request must be made to: VP of Treatment Programs, 215 Washington Street, West Warwick, RI.

[I/We] may deny your request for a variety of reasons. If [I/we] deny your request, [I/we] will inform you in writing of the reason(s) for the denial and explain your rights regarding responding to the denial.

If [I/we] agree to your request, [I/we] will change your PHI, inform you of the change, and tell others who need to know about the change to your PHI.

F. Breach Notification. If there is a breach of unsecured PHI concerning you, [I/we] will notify you of this breach as required by law, including what happened and what you can do to protect yourself.

G. Your Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you agreed to receive it electronically. You may request a paper copy at any time.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO FILE A COMPLAINT ABOUT [MY/OUR] PRIVACY PRACTICES.

If you have any questions about this notice, wish to exercise any of the rights explained in it or file a complaint about [my/our] privacy practices, feel that [I/we] may have violated your privacy rights, or disagree with a decision [I/we] made about your PHI, please contact: VP of Treatment Programs, 215 Washington Street, West Warwick, RI.

You also may send a written complaint to: Office for Civil Rights, U.S. Department of Health and Human Services, J. F. Kennedy Federal Building, Room 1875, Boston, MA 02203. [I/We] will not retaliate against you for filing a complaint.

VI. EFFECTIVE DATE OF THIS NOTICE.

This notice is effective as of September 20, 2013, and supersedes any and all prior versions of this notice.

Written Acknowledgement of Receipt of Privacy Practices

I acknowledge receipt of Tides Family Services' Notice of Privacy Practices.

_____	_____
Client's Name	Client's Authorized Representative
_____	_____
Client's Signature	Relationship to Client
_____	
Date	