Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices

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.

Claris Health (CH) is required, by law, to maintain the privacy and confidentiality of your protected health information to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information and to notify you in the event of a breach of your unsecured protected health information. When we use or disclose your protected health information, we are required to abide by the terms of this notice.

I. Uses and Disclosures of Your Health Care Information Without Written Authorization

We may use or disclose your protected health information without your written authorization for the following purposes:

Treatment, Payment and Health Care Operations

We may use or disclose your protected health information for your treatment, for payment for health care services provided to you or for health care operations. For example:

- Treatment - We may need to seek consultation regarding your condition from other health care providers associated with Claris Health Pregnancy Clinic. We may also use your information to direct you to certain alternative treatments, therapies, health care providers or settings of care.

- Payment - While most of our services are currently performed without charge or at low-cost there are certain times when we may submit a claim for payment to Medi-Cal for health care services we provide you.

- Health Care Operations – We may use and disclose protected health information for CH own internal administration, planning and various activities to improve the quality of care we deliver to you. In addition, in the event that CH merges with another organization, your health information/record will become the property of the new owner.

Emergencies
We may disclose health information to notify or assist in notifying a family member or another person responsible for your care in the event of an emergency.

Disclosure to Relatives, Close Friends and Other Caregivers Physically Present With You.
We may disclose your protected health information to a family member, a close personal friend or any other person who is physically present with you at the time we provide you with services, and we can reasonably infer that you do not object to the disclosure.

As Required by Law.
We may use and disclosure your protected health information when required to do so by any applicable law.

Public Health
We may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug

Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Health Oversight Activities.
We may disclose your protected health information to an agency responsible for ensuring compliance with government health care program rules, such as Medicaid.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Victims of Abuse, Neglect or Domestic Violence
We may use and disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your information if necessary to prevent serious threat to your health or safety or the health or safety of others.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

II. Uses and Disclosures of Your Health Care Information With Written Authorization

Marketing
We must obtain your written authorization to use or disclose your protected health information for marketing communications (other than face-to-face encounters and to give you a promotional gift of nominal value).

Sale of Protected Health Information
We will not sell your protected health information without your written authorization.

Psychotherapy Notes
We will not use or disclose your psychotherapy notes without your written authorization except for your treatment, payment for your care or to defend ourselves in a legal action or other proceeding brought by you.

Highly Confidential Health Information

Federal and California law requires special privacy protections for certain highly confidential health information about you, including alcohol and drug abuse treatment program records, HIV/AIDS status and genetic information. We will obtain your authorization before disclosing any of your highly confidential health information.

All other uses and disclosures of your protected health information not described in this notice will be made only with your written authorization.

III. Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that CH is not required to agree to the restriction that you requested unless the request is required by law.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that the CH amends your protected health information. Please be advised, however, that CH is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by the CH.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
CH reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. If we change this Notice, we will post the new notice in our waiting room and on our internet site at www.clarispregnancy.org.
If you have questions about any part of this notice or if you want more information about your privacy rights, please call this office at (310) 268-8400 and ask for the CEO. If the CEO is not available, you may make an appointment for a conference in person or via telephone within 2 working days.

Complaints
Complaints about your Privacy Rights or about how CH has handled your health information should be directed to the CEO by calling the office at (310) 268-8400. If the CEO is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of, May 18, 2015

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In accordance with the above privacy practices (please check all that apply),

A. I consent to being contacted by phone at this number_____ for any communication needs.

[ ] I consent to the leaving of voicemail or text messages that may include content that discloses my use of any service provided by CH.
[ ] I consent to phone calls BUT no voicemail messages or text messages.
[ ] I consent to phone calls and text messages BUT no voicemail messages.
[ ] I consent to phone calls and voicemail messages BUT no text messages.

B. [ ] I consent to being contacted by email at this email address _____ for any communication needs. I understand that messages may include content that disclose my use of any service provided by CH.

C. [ ] I consent to being contacted by standard snail mail at this mailing address _____ for any communication needs. I understand that mailings may include content that discloses my use of any service provided by CH.

D. [ ] I DO NOT consent to any form of communication. I understand that this may negatively impact my care (e.g. delay treatment or initiation of services).

I have read the HIPAA Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide CH with my authorization and consent to use and disclose my protected health care information as described in the HIPAA Privacy Notice. I also authorize to be contacted by the method selected above for information related to my care at CHPC.

_____ _____
Patient's Name (Print in all CAPS) Date

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date