Dear Parents/Guardians,

Welcome to Learn and Play ABA at ACDS Westchester! We are grateful that you are interested in our program and look forward to meeting you and your family. Learn and Play ABA at ACDS Westchester opened its doors in Scarsdale, NY in February of 2020. It is a center-based ABA (Applied Behavior Analysis) program that provides one-on-one therapy for children diagnosed with Autism. Learn and Play ABA looks to provide quality, caring service to each child that is enrolled. Each staff member is highly trained and dedicated to meet the needs of the families and children they serve.

The first step in enrolling in our program is completing the necessary paperwork for your child. Please thoroughly fill out each page of the client intake packet that is provided below. Once you have completed the forms you may submit it by mail, drop it off or email it to Learn and Play ABA. In addition to the intake packet, attach all medical documentation relating to the autism diagnosis (this must include the 5 AXIS) and a copy of your child’s insurance card. I will be in contact with you when I receive the packet to continue the intake process. If you have any questions along the way, please contact me during our scheduled business hours.

Thanks again for your interest in our program!

Sincerely,
Amanda McKiernan
Board Certified Behavior Analyst, Director
(914) 810-2237 ext. 104
amckiernan@acds.org
Client Start Date: ____________________________  
(Office to complete)  
Today’s Date: ____________

Client Legal Name: ____________________________________________

Name Client goes by: ____________________________ Date of Birth: ____________ Gender: __M / F

Home Address: __________________________________________________________________________________________________________________________________________________________________________________________________________________________

City: ____________________________ State: ____________ Zip: ____________

**Family Information**

Client lives with: __________________________________________________________________________________________________________________________________________________________________________________________________________________________

**Parent/Guardian 1**
Name: ____________________________________________ Relationship: ____________________________

Address: ____________________________ City: ____________ State: ____________ Zip: ____________

Home Phone: ____________________________ Cell Phone: ____________________________

E-mail Address: __________________________________________________________________________________________________________________________________________________________________________________________________________________________

Employed by: ____________________________ Occupation: ____________________________

Employer Address: ____________________________ Employer Phone: ____________________________

**Parent/Guardian 2**
Name: ____________________________________________ Relationship: ____________________________

Address: (if different) ____________________________ City: ____________ State: ____________ Zip: ____________

Home Phone: (if different) ____________________________ Cell Phone: ____________________________

E-mail Address: __________________________________________________________________________________________________________________________________________________________________________________________________________________________

Employed by: ____________________________ Occupation: ____________________________

Employer Address: ____________________________ Employer Phone: ____________________________
Emergency Contact Information

I give permission to Learn and Play ABA at ACDS Westchester to take whatever emergency decisions are judged necessary for the care and protection of my child while at Learn and Play ABA. Please provide the name and phone number of individuals who can be called in case of an emergency when parents/guardians are not available.

Emergency Contact: ______________________ Relationship: ______________________
Home Phone Number: ______________________ Cell Phone Number: ______________________

Insurance Information

I understand that in some medical situations, the staff will need to contact local emergency resources before the parent/guardian, child’s physician and or other adult acting on the parent/guardian’s behalf.

Name of Primary Insurance: (Private or MA) ______________________
Member Number/MA number: ______________________ Group Number: ______________________
Subscriber Name: ______________________

I prefer: ___ Pay my balance in full at time of service
___ Pay my balance in full upon receipt of first statement
___ Make payment arrangements prior to services being rendered

Assignment of Insurance Benefits

I understand the confidentiality of my records as protected by law. Information about me/my child cannot be released without my consent. I understand I may revoke this consent at any time, and it will automatically expire without my revocation after one (1) year from the date of signature.

I hereby give authorization for Learn and Play ABA at ACDS Westchester to contact and inform my primary and secondary (if applicable) insurance companies of all medical information included in treatment plans relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this documents authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize the Insurance Companies named above to pay and hereby assign directly to ACDS Westchester all benefits, if any, otherwise payable to me for his/her services. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received and paid to ACDS Westchester will be credited to my account, in accordance with the above assignment.

_______________________________________________________________                             ____________________
(Authorized signature of Subscriber)                             (Date)
**Medical Information**

Hospital/Clinic Preference: ______________________________________________________________

Client’s Primary Doctor: ___________________ Doctor Phone Number: ______________________

Allergies: __________________________________________________________________________

List any medication routinely taken at home: ______________________________________________

Name of medications to be left at ACDS Westchester: ______________________________________

**An additional Permission to Administer Medication form will need to be completed and on file for each specific medication your child takes at Learn and Play ABA at ACDS Westchester.**

List any medical restrictions to client’s activities: __________________________________________

List any special dietary needs: __________________________________________________________

Family composition/recent family changes: ______________________________________________

Medical conditions or other psychological conditions or hospitalizations: ________________________________________________________________________

**Additional Service Providers**

Social Worker: ___________________ Phone Number: ________________________________

Interpreter: ___________________ Phone Number: ________________________________

School: ___________________ Grade: ____________________

Teacher’s Name: ___________________ Phone Number: __________________________

**Other Providers (if applicable)**

Name: ___________________ Type of service: ___________________ Phone number: _____________

Name: ___________________ Type of service: ___________________ Phone number: _____________

Name: ___________________ Type of service: ___________________ Phone number: _____________

Name: ___________________ Type of service: ___________________ Phone number: _____________
Pregnancy and Birth History:

Was the pregnancy _____planned or _____unplanned? Was it full-term? ____Yes ____No

How did the mother feel about this pregnancy?

How did the father feel about this pregnancy?

Was any alcohol, drugs, or medications used during pregnancy? _____Yes _____No

If yes, please describe:

Did either parent smoke during the pregnancy? Who?

Were there any problems with the pregnancy?

Were there any problems with the birth?

Child Developmental History

Development:

Was the baby _____breast fed _____ bottle fed _____both

Who was the primary caretaker for the child? ____________________________________________

Estimate when your child first:

Smiled _____
Sat up on own _____
Crawled ________
Stood ________
Walked ________
Ran ________
Said first word ______
Said phrases ______
Fed self ______
Dressed self ______
Toilet trained ______

Were there any illnesses, hospitalizations, or injuries?

Were there any behavioral difficulties or discipline problems during early childhood?

Did your child have temper tantrums? _____Yes _____No
Describe:

Does your child or has your child ever engaged in Self-Injurious Behavior? _____ Yes _______ No

Describe:

What discipline techniques were used? Did the parents use consistent discipline?

**Family History:**

Are the parents of the child married, separated, or divorced? If they are separated or divorced, what are the custody arrangements? Have there been any problems with the custody arrangements?

Please list all members of the household, their ages, and their relationship to your child:

Are there any traditions/events that are important to your child?

Is there any additional information you feel would be helpful to the treatment of your child?

What are your expectations for treatment?

Is your family currently utilizing community resources; such as, support groups, social services, school-based services or other social supports?
Possible Reinforcers

Please list all or any preferences that your child has shown and put * next to the ones that are highly preferred in each category. Be as SPECIFIC as possible!!

FOOD: (snacks, candies, chocolate – please be specific; kind or brand names)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

TOYS: (games, stuff animals, etc.)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

PHYSICAL CONTACT: (tickles, hugs, kisses, clapping, back rubs, etc.)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

ACTIVITIES: (reading books, listen to music, etc.)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

OTHER: (any special preferences not mentioned)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
**Service Coordination**

Child’s Name: ______________________________ Date: ______________

Service Coordination:

We at ACDS Westchester require providers to coordinate services. If your child is receiving any of the following, indicate the number of hours of service per day and the frequency of the service.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Hours</th>
<th>Frequency</th>
<th>Current or Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Education Services</td>
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<tr>
<td>Recreational Therapy</td>
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<td>Psychiatrist</td>
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<td>Physical Therapy</td>
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<td>Speech Therapy</td>
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<tr>
<td>Occupational Therapy</td>
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<tr>
<td>Family Psychotherapy Services</td>
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<td></td>
<td></td>
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<tr>
<td>Other (explain)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Release of Consent

Client name: _______________________

- I understand that my records are protected by data practice laws and cannot be released without my consent unless otherwise allowed by law.
- I understand that only the information and records indicated below will be released or obtained.
- I understand that this consent does not authorize the recipient of the information or records to re-disclose the information or records to any other person or facility unless authorized by law.
- I understand that the information will only be used for the purposes indicated below.
- I understand that I may withdraw or modify this consent at any time but, that the revocation or modification will not affect any release of information that previously occurred.
- I understand that this consent will expire and no longer be valid one year after the date it was signed.
- I understand that the observation and/or assessment can take place in either setting.

I Authorize:

Learn and Play ABA at ACDS Westchester
963 Scarsdale Rd
Scarsdale, NY 10583
Name of Staff: _______________________

To obtain records from or release records to:

Name of Agency: _______________________
Name of Staff: _______________________

Type of information released:

- ___Assessments or evaluations
- ___Behavior reports
- ___All
- ___Educational records
- ___Medical records
- ___Other:

Information may be shared in person or by mail. I also give permission to share information using the following methods:

- ___Phone
- ___Fax
- ___Email
- ___Other:
- ___All

________________________________________  ________________________________
Parent or Guardian or Authorized Representatives Signature  Date

Federal Law: “This information has been disclosed to you from records whose confidentiality is protected by Federal Law prohibits disclosing this material. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.”
Treatment/ Assessment Agreement

This agreement is hereby made and into this day of _____________ by and between ______________________________ and Learn and Play ABA at ACDS Westchester. The said parties, hereby agree to the following:

Consent for Treatment. I now voluntarily consent to assessment and treatment performed by clinicians with Learn and Play ABA at ACDS Westchester. This consent for treatment is valid for all care that is provided for at least one (1) year from the date I sign this agreement. I understand that I can revoke this consent for treatment at any time in writing to Learn and Play ABA at ACDS Westchester main office.

Payment Agreement. Whether I sign as the client or as the guardian, conservator or agent of the client, I assume full responsibility for and agree to pay all costs, charges, and expenses for services rendered. Each bill for all Learn and Play ABA at ACDS Westchester charges shall be due and payable by the client, parent, his/her agent, guardian, conservator, or third party responsible for payment at time of service or on the date stated on the bill. I now agree to pay all costs and fees, including attorney fees, in the event Learn and Play ABA at ACDS Westchester brings any action because of any failure by someone or me on my behalf to pay Learn and Play ABA at ACDS Westchester bills in full.

Preauthorization Requirements. I understand that it is my responsibility to obtain all pre-authorizations and to comply with all requirements of any insurance plan that I am relying on for coverage of Learn and Play ABA at ACDS Westchester charges.

Cancellation. Should I be unable to attend my scheduled appointment, I will notify by phone my clinician, leaving a message as necessary. I understand that I will be billed $75 if Learn and Play ABA has not been notified by 2pm the day prior to my scheduled session, or by 2pm on Fridays for sessions scheduled on Mondays. Please note that insurance will not reimburse for missed appointments.

Treatment Cooperation. I/we agree to cooperate with Learn and Play ABA at ACDS Westchester’s efforts to provide services to my child and my family and I/ we will participate in the treatment process and will follow through with any interventions recommended by Learn and Play ABA at ACDS Westchester. This includes weekly mandatory parent training sessions. I/we agree to notify Learn and Play ABA at ACDS Westchester of any changes in diets, medication, or the addition of other treatments prior to the onset of these changes or immediately thereafter.

Payment. I/we hereby agree to pay Learn and Play ABA at ACDS Westchester, for service amount, which is listed on the attached fees for services form at the time the invoice is received. I understand that services include record reviews, copays, phone consultations, report writing, program development, and observations conducted in other environments. Services are billed in 15-minute increments.
Therapists. Learn and Play ABA at ACDS Westchester will supervise and monitor services provided to me by Learn and Play ABA at ACDS Westchester therapists and/or individual therapists and consultants. These therapists and consultants may be employees or independent contractors of Learn and Play ABA at ACDS Westchester and will be supervised according to the requirements set forth by the New York State Office of the Professions and the Behavior Analyst Certification Board. All scheduling will occur between myself/us and the therapist. Therapists are not permitted to babysit for their clients at any time or under any circumstance.

Risks. I/we understand that there is a risk associated with any time of therapy or intervention. I/we agree that to the fullest extent permitted by law, Learn and Play ABA at ACDS Westchester shall not be liable to Client for any special, indirect, or consequential damages whatsoever, whether caused by Learn and Play ABA at ACDS Westchester negligence, breach of contract, or other cause or causes whatsoever including, but not limited to, loss of behavioral consulting services and the costs related to locating a new provider of such consulting services. This does not include willful or intentional wrongs.

Solicitation. I/we agree not to solicit Learn and Play ABA at ACDS Westchester staff that work with my child for privately paid services. This includes babysitting, more therapy hours, etc.

Service Cancellation. I/we agree to give Learn and Play ABA at ACDS Westchester two weeks notice if we wish to terminate services. We understand that emergency situations may arise, but the proper transition away from services is important to your child and family’s success.

I HAVE READ AND UNDERSTAND THIS AGREEMENT. IT HAS BEEN FULLY EXPLAINED TO ME AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED. BY SIGNING THIS FORM, I UNDERSTAND AND AGREE TO THE TERMS STATED ABOVE.

____________________________________________________________________________
Parent/Guardian Signature Date

____________________________________________________________________________
Financially Responsible Party (if not client or parent) Date

____________________________________________________________________________
Amanda McKiernan, M. Ed., BCBA, LBA, Director
**Client Notification of Privacy Rights**

Health Insurance Portability and Accountability Act (HIPAA)

Recent federal law, the Health Insurance Portability and Accountability Act (HIPAA), has created new client protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides client protections related to electronic transmission of data, the keeping and use of client records, and the storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Client Notification of Privacy Rights is designed to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can do to protect the privacy of your mental health records.

HIPAA requires that we secure your signature indicating you have received or been offered the Client Notification of Privacy Rights document.

I have accepted a copy of the Client Notification of Privacy Rights document. 

I have been offered a copy of the document and do not wish to have a copy at this time. 

(I understand I have the right to review the document before signing this acknowledgement form.)

___________________________  ____________________________
Client’s Name (print)          Client or Legal Guardian Signature

___________________________  ____________________________
Client Date of Birth          Date Signed

Please sign and return this page to the office. You may retain the notification document for your records.
E-Mail Consent to Communicate with Providers

Client/Guardian Name: _________________________________________________

RISKS:
1. The confidentiality of e-mail communication cannot be assured.
2. E-mail communication may be viewed by third parties.
3. E-mail is sent across an open computer network and is generally unencrypted. It is thus accessible to prying eyes similar to a postcard.
4. E-mail sent using an employer's e-mail system could legally be read by the employer.
5. The biggest threat to the confidentiality of e-mail is not hackers intercepting messages, but messages that are misaddressed, mistakenly forwarded to others, or are read using shared e-mail accounts or on computer screens when one forgets to log-off.

BENEFITS:
1. Use of e-mail may eliminate “telephone tag” between client and health care provider.
2. Non-urgent messages and questions may be communicated with less interruption than by phone.
3. E-mail allows a written record of communication, which can be a useful resource.

GUIDELINES FOR E-MAIL COMMUNICATION:
Appropriate uses of e-mail for medical communication include:
   1. Address and telephone numbers of referring facilities;
   2. Assessment results with interpretation and recommendation;
   3. Before-admission and after-discharge instructions;
   4. Client education;
   5. Questions and answers about issues discussed during a previous visit;
   6. Questions and answers about new symptoms by an established client;
   7. Verification of future appointment dates/times;
   8. Other messages of a similar nature to the topics above.

E-mail SHOULD NOT be used to communicate:
   1. Emergencies and other time-sensitive issues.
   2. Sensitive information, defined as any information that the client would not want anyone other than the health care provider to have.

This consent form applies to all health care providers who are providing care to you. Either the client or health care provider may terminate e-mail correspondence at any time.
I, ________________________________ (name of client/guardian) understand the risks, benefits, and appropriate uses of e-mail communication with my providers.

_____ I have reviewed the information above and wish to proceed.
_____ I do not wish to have staff correspond with myself or other therapists by email.

__________________________________ / ________________________________ / __________________
Client/Guardian E-mail Address/ Signature Date
Appointment Cancellation Policy Agreement:

Learn and Play ABA at ACDS Westchester is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (914) 810-2237 ext. 104 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations.

To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.

If prior notification is not given, you will be charged $75 for the missed appointment.

This will not be covered by your insurance company. Please sign below to consent to these terms.

________________________________________
Parent/Guardian Signature, Date
### FACE Sheet
Please complete the form below by providing as much information as possible regarding your child. This information will be given to medical personnel in case of an emergency.

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth Date</th>
<th>Parent/Guardian</th>
<th>Home Address</th>
<th>Home Phone Number</th>
<th>Cell Phone Number</th>
<th>Work Phone Number</th>
<th>Primary Insurance</th>
<th>Secondary Insurance</th>
<th>Hospital/Clinic Preference</th>
<th>Primary Doctor</th>
<th>Allergies</th>
<th>Other Information</th>
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</tr>
</tbody>
</table>

**Learn and Play ABA at ACDS Westchester**
963 Scarsdale Rd Scarsdale, NY 10583
(914) 810-2237

________________________
Parent or Legal Guardian Signature

________________________
Date
Additional Information

Thank you for completing the client registration packet. In addition to submitting the application packet, please include the following items when applying for enrollment:

- Copy of your child’s insurance card(s)
- Medical documentation pertaining to the diagnosis of autism
- Reports from other service providers (if applicable)
  - Speech therapy, school services, occupational therapy, etc.

Please contact Learn and Play ABA if you have any questions when completing the application packet, or regarding the intake process.

Thanks again,

Amanda McKiernan
Board Certified Behavior Analyst/ Director
(914) 810-2237 ext. 104
amckiernan@acds.org
NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION
[45 CFR 164.520]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity’s obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).

- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).

- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

- How the covered entity may use and disclose protected health information about an individual.
• The individual’s rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.

• The covered entity’s legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.

• Whom individuals can contact for further information about the covered entity’s privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

• A covered entity must make its notice available to any person who asks for it.

• A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.

• **Health Plans** must also:
  ➢ Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  ➢ Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  ➢ Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

• **Covered Direct Treatment Providers** must also:
  ➢ Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual’s written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  ➢ When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual’s first request for service. The provider must make a good faith effort to obtain a return receipt or other
transmission from the individual in response to receiving the notice.

➢ In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.

➢ Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider’s office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

• A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

• Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

• Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices

FAQs on ALL Privacy Rule Topics

You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.
ACCESS TO HEALTH RECORDS
NOTICE OF RIGHTS

This notice explains the rights you have to access your health record, and when certain information in your health record can be released without your consent. This notice does not change any protections you have under the law.

YOUR RIGHT TO ACCESS AND PROTECT YOUR HEALTH RECORD
You have the following rights relating to your health record under the law:

- A health care provider, or a person who gets health records from a provider, must have your signed and dated consent to release your health record, except for specific reasons in the law.
- You can ask to see your health record for information about any diagnosis, treatment, and prognosis.
- You can ask, in writing, for a copy or summary of your health record, which must be given to you promptly.
- You must be given a copy or a summary of your health record unless it would be detrimental to your physical or mental health, or cause you to harm to another.
- You cannot be charged if you request a copy of your health record to review your current care.
- If you request a copy of your health record and it does not include your current care, you can only be charged the maximum amount set by Minnesota law for copying your record.

RELEASE OF YOUR HEALTH RECORD WITHOUT YOUR CONSENT
There are specific times that the law allows some health record information held by your provider to be released without your written consent. Some, but not all, of the reasons for release under federal law are:

- For specific public health activities
- For health oversight activities
- For judicial and administrative proceedings
- For specific law enforcement purposes
- For certain organ donation purposes
- When health information about decedents is required for specific individuals to carry out their duties under the law
- For research purposes approved by a privacy board
- To stop a serious threat to health or safety
- For specialized government functions related to national security
- For workers’ compensation purpose

Under Minnesota law, health record information may be released without your consent in a medical emergency, or when a court order or subpoena requires it. The following include some of the agencies, persons, or organizations that specific health record information may or must be released to for specific purposes, or after certain conditions are met:

- The Departments of Health, Human Services, Public Safety, Commerce, Minnesota Management & Budget, Labor & Industry, Corrections, and Education
- Insurers and employers in workers’ compensation cases
- Ombudsman for Mental Health and Developmental Disabilities
- Health professional licensing boards/agencies
- Victims of serious threats of physical violence
- The State Fire Marshal
- Local welfare agencies
- Medical examiners or coroners
- Schools, childcare facilities, and Community Action Agencies to transfer immunization records
- Medical or scientific researchers
- Parent/legal guardian who did not consent for a minor’s treatment, when failure to release health information could cause serious health problems
- Law enforcement agencies
- Insurance companies and other payers paying for an independent medical examination

If you would like additional information or links to specific laws, visit www.health.state.mn.us and search for “access to health records” or call the Minnesota Department of Health at (651) 201-5178.

Minnesota Statutes, section 144.292, subdivision 4

This notice may be photocopied.

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