

Subject: NOTICE OF PRIVACY PRACTICES

Revision Date: 02/08/2023

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### **EIHAB Notice of Privacy Practices**

This notice describes the privacy practices of EIHAB Human Services and the privacy rights of the people we serve. It will describe how information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy rule DOES NOT CHANGE the way you get services from EIHAB, or the privacy rights you have always had under federal and state laws. The Privacy rule adds some details about how you can exercise your rights.

### **PLEASE REVIEW THIS NOTICE CAREFULLY.**

This notice is effective as of February 13, 2023

#### **Our Privacy Commitment to You:**

EIHAB provides many different services to you. We understand that information about you and your family is personal. We are committed to protecting your privacy and sharing information only with those who need to know and are allowed to see the information to assure quality services for you. EIHAB is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. This notice tells you how EIHAB uses and discloses information about you. It describes your rights and what EIHAB's responsibilities are concerning information about you. When we use the word "you" in this Notice, we also mean your personal representative. Depending on your circumstances and in accordance with state law, this may mean your guardian, your health care proxy, or your involved parent, spouse, or involved adult family member.

If you have questions about any part of this notice or if you want more information about the privacy practices at EIHAB, please contact:

*Privacy Officer*

*Address: 168-18 South Conduit Ave., Springfield Gardens, NY 11434*

*Phone: 718-276-6101*

*E-mail: [PrivacyOfficer@eihab.org](mailto:PrivacyOfficer@eihab.org)*

#### **Who will follow this Notice:**

All people who work for EIHAB will follow this notice. This includes employees, persons EIHAB contracts with who are authorized to enter information in your record or need to review your record to provide services to you, and volunteers who EIHAB allows to assist you.

#### **What information is protected:**

All information that we create or keep that relates to your health or care and treatment, including but not limited to your name, address, birth date, social security number, your medical information, your service or treatment plan, and other information (including photographs or other images) about your care in our programs, is considered protected information. In this Notice, we refer to protected information as protected health information or "PHI". We create and collect information about you and we keep a record of the care and services you receive through this agency. The information about you is kept in a record; it may be in the form of paper documents in a chart or on a computer. We refer to the information that we create, collect, and keep as a "record" in this Notice.

#### **Your Health Information Rights:**

Unless otherwise required by law, your record is the physical property of EIHAB, but the information in it belongs to you and you have the right to have your information kept confidential. You have the following rights concerning your PHI:

- You have a right to see or inspect your PHI and obtain a copy of the information. Some exceptions apply, such as information compiled for use in court or administration proceedings. NOTE: EIHAB requires you to make your request for records in writing to the Privacy Officer. You may request copies in paper format or in an electronic form such as a CD, portable device, or memory stick. In some instances, we may charge you for copies.
- If we deny your request to see your information, you have the right to request a review of that denial. The Chief Executive Officer will appoint a licensed health care professional to review the record and decide if you may have access to the record.
- You have the right to ask EIHAB to change or amend information that you believe is incorrect or incomplete. We may deny your request in some cases, for example, if the record was not created by EIHAB or if after reviewing your request, we believe the record is accurate and complete.
- You have the right to request a list of the disclosures that EIHAB has made of your PHI. The list, however, does not include certain disclosures, such as those made for treatment, payment, and health care operations, or disclosures made to you or made to others with your permission.
- You have the right to request a restriction on uses or disclosures of your health information related to treatment, payment, health care operations, and disclosures to involved family. EIHAB, however, is not required to agree to your request.
- You have the right to request that EIHAB communicate with you in a way that will help keep your information confidential. You may request alternate ways of communication with you or request that communications are forwarded to alternative locations.
- You have the right to limit disclosures to insurers if you have paid for the service completely out of pocket.
- You will be notified if there is a breach of unsecured PHI containing your information; we are required by federal law to provide notification to you.
- To request access to your clinical information or to request any of the rights listed here, you may contact:

Privacy Officer

Address: 168-18 South Conduit Ave., Springfield Gardens, NY 11434

Phone: 718-276-6101

E-mail: [PrivacyOfficer@eihab.org](mailto:PrivacyOfficer@eihab.org)

We will require you to submit your requests in writing to the Privacy Officer.

***NOTE: Other regulations may restrict access to HIV/AIDS information, federally protected education records, and federally protected drug and alcohol information. See any special authorizations or consent forms that will specify what information may be released and when, or contact the Privacy Officer listed above.***

### **Our Responsibilities to You:**

We are required to:

- Maintain the privacy of your information in accordance with federal and state laws.
- Give you this Notice that tells you how we will keep your information private.
- Tell you if we are unable to agree to a limit on the use or disclosure that you request.
- Carry out reasonable requests to communicate information to you by special means or at other locations.
- Get your written permission to use or disclose your information except for the reasons explained in this notice.
- We have the right to change our practices regarding the information we keep. If practices are changed, we will tell you by giving you a new notice. Notices will be posted on our website: [www.eihab.org](http://www.eihab.org)

### **How EIHAB Uses and Discloses Your Health Information:**

EIHAB may use and disclose information without your permission for the purposes described below. For each of the categories of uses and disclosures, we explain what we mean and offer an example. Not every use or disclosure is described, but all of the ways we will use or disclose information will fall within these categories.

- **Treatment:** EIHAB will use your information to provide you with treatment and services. We may disclose information to doctors, nurses, psychologists, social workers, and other EIHAB personnel, volunteers, or interns who are involved in providing your care. For example, involved staff may discuss your information to develop and

carry out your treatment or service plan and other EIHAB staff may share your information to coordinate different services you need, such as medical tests, respite care, transportation, etc. We may also need to disclose your information to other providers outside of EIHAB who are responsible for providing you with services.

- **Payment:** EIHAB will use your information so that we can bill and collect payment from you, a third party, an insurance company, Medicare or Medicaid, or other government agencies. For example, we may need to provide your health care insurer with information about the services you received in our agency or through one of our programs so they will pay us for the services. In addition, we may disclose your information to receive prior approval for payment for services you may need.
- **Health Care Operations:** EIHAB will use clinical information for administrative operations. These uses and disclosures are necessary to operate EIHAB programs and to make sure all individuals receive appropriate, quality care. For example, we may use information for quality improvement to review our treatment and services and to evaluate the performance of our staff in serving you.

We may also disclose information to clinicians and other personnel for on-the-job training. We will share your health information with other EIHAB staff for the purposes of obtaining legal services from our attorneys, conducting fiscal audits, and for fraud and abuse detection and compliance through our Compliance Program. We may also disclose information to our business partners who need access to the information to perform administrative or professional services on our behalf.

#### **Other Uses and Disclosures that Do Not Require your Permission:**

In addition to treatment, payment, and health care operations, EIHAB will use your information without your permission for the following reasons:

- When we are **required to do so by federal or state law**.
- For **public health reasons**, including prevention and control of disease, injury or disability, reporting births and deaths, reporting child abuse or neglect, reporting reactions to medication or problems with products, and to notify people who may have been exposed to a disease or are at risk of spreading the disease.
- To report **domestic violence and adult abuse or neglect** to government authorities if necessary to prevent serious harm.
- For **health oversight activities**, including audits, investigations, surveys and inspections, and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws. Health oversight activities do not include investigations that are not related to the receipt of health care or receipt of government benefits in which you are the subject.
- For **judicial and administrative proceedings**, including hearings and disputes. If you are involved in a court or administrative proceeding, we will disclose information if the judge or presiding officer orders us to share the information.
- For **law enforcement purposes**, in response to a court order or subpoena, to report a possible crime, to identify a suspect or witness or missing person, to provide identifying data in connection with a criminal investigation, and to the district attorney in furtherance of a criminal investigation of client abuse.
- Upon your death, to **coroners or medical examiners** for identification purposes or to determine cause of death, and to **funeral directors** to allow them to carry out their duties.
- To organ procurement organizations to accomplish cadaver, eye, tissue, or **organ donations** in compliance with state law.
- For **research** purposes when you have agreed to participate in the research and the Privacy Oversight Committee has approved the use of the clinical information for the research purposes.
- To **prevent or lessen a serious and imminent threat** to your health and safety or someone else's.
- To authorized federal officials for intelligence and other **national security** activities authorized by law or to provide **protective services to the President** and other officials.
- To **correctional institutions** or **law enforcement officials** if you are an inmate and the information is necessary to provide you with health care, protect your health and safety or that of others, or for the safety of the correctional institution.
- To **governmental agencies that administer public benefits** if necessary to coordinate the covered functions of the programs.

#### **Uses and Disclosures that Require Your Agreement:**

EIHAB may disclose information to the following persons if we tell you we are going to use or disclose it and you agree or do not object:

- To **family members and personal representatives** who are involved in your care if the information is relevant to their involvement and to notify them of your condition and location.
- To **disaster relief organizations** that need to notify your family about your condition and location should a disaster occur.
- For **fundraising** purposes, we may disclose information to a charitable program that assists us in fundraising with your permission. You have the right to refuse or opt out if you previously agreed to communications regarding fundraising.
- For **marketing** of health- related services, we will not use your health information for marketing communications without your permission.
- To disclose **psychotherapy** notes.

#### **Authorization Required For All Other Uses and Disclosures:**

- For all other types of uses and disclosures not described in this Notice, EIHAB will use or disclose information only with a written authorization signed by you that states who may receive the information, what information is to be shared, the purpose of the use or disclosure and an expiration for the authorization. Written authorizations are always required for the sale of PHI and use and disclosure for marketing purposes, such as agency newsletters and press releases.

**Note:** If you cannot give permission due to an emergency, EIHAB may release information in your best interest. We must tell you as soon possible after releasing the information.

You may revoke your authorization at any time. If you revoke your authorization in writing we will no longer use or disclose your information for the reasons stated in your authorization. We cannot, however, take back disclosures we made before you revoked and we must retain information that indicates the services we have provided to you.

#### **Changes to this Notice:**

**We reserve the right to change this Notice.** We reserve the right to make changes to terms described in this Notice and to make the new notice terms effective to all information that EIHAB maintains. We will post the new notice with the effective date on our website at [www.eihab.org](http://www.eihab.org) and in our facilities. In addition, we will offer you a copy of the revised notice at your next scheduled service planning meeting.

#### **Complaints:**

If you believe your privacy rights have been violated, you may file a complaint with:

- Privacy Officer  
Address: 168-18 South Conduit Ave., Springfield Gardens, NY 11434  
Phone: 718-276-6101  
E-mail: [PrivacyOfficer@eihab.org](mailto:PrivacyOfficer@eihab.org)
- Or, you may contact the Director of Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201, Secretary of the Department of Health and Human Services. You may call them at (877) 696-6775 or write to them at 200 Independence Ave. S.W., HHH Building Room 509H, Washington DC, 20201.
- You may file a grievance with the Office of Civil Rights by calling or writing Region II – US Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278, Voice Phone (800) 368-1019, FAX (212) 264-3039, TDD (800) 537-7697.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**



Empowering  
Instructing  
Habilitating  
Assisting

Eihab Human Services, Inc.  
168-18 South Conduit Avenue, Springfield Gardens, NY 11434  
718-276-6101 Fax 718-276-6063 PrivacyOfficer@eihab.org

### EIHAB Acknowledgement of Receipt of Notice

I hereby acknowledge that I have received a copy of EIHAB Notice of Privacy Practices.

Yes \_\_\_ No \_\_\_ I would like to receive a copy of any amended Notice of Privacy Practices

at: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the individual, please indicate relationship:

- Parent or guardian of individual
- Health Care Proxy or Agent
- Beneficiary or personal representative of deceased individual
- Other

Name of Individual: \_\_\_\_\_

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#### ***For Office Use Only:***

Signed form received by: \_\_\_\_\_

Acknowledgment refused:

Efforts to obtain:

\_\_\_\_\_  
\_\_\_\_\_

Reasons for refusal:

\_\_\_\_\_  
\_\_\_\_\_