



## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW YOUR MEDICAL/CLINICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The information contained in your records is considered sensitive. Please review the following information carefully.

At **Premier Behavioral Health Services (PBHS)**, we believe your health information/clinical records are personal and contain sensitive information. We maintain a record of the care and services that are provided to you and are committed to keeping this information private, and the law requires that your confidentiality be respected and maintained.

This Notice contains information regarding privacy practices at *PBHS*, and it applies to all the health information that identifies you and the treatment you receive at our practice. This information may consist of paper records, digital or electronic records, as well as possible pictures or videos and other electronic transmissions or recordings that are created as part of your care and treatment. Federal and state laws require us to protect your health information, and federal law further requires us to describe how we handle that information. When federal and state privacy laws are different and conflict with each other, and the state law is more protective of your information or provides you with greater protection to your information, then we follow state law. For example, where we have identified specific state law requirements in this Notice, *PBHS* will follow the more protective state law requirements.

All clinical providers and non-clinical staff at *PBHS* follow the terms of this Notice.

### **HOW *PBHS* MAY USE AND DISCLOSE YOUR HEALTH INFORMATION**

As a patient/client of *PBHS*, your health information will be used in our practice and disclosed outside of *PBHS* for reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.

#### **Treatment/Clinical Care**

Health information is utilized to provide you with health care services. We may disclose your information to clinicians in our practice (they include physicians, nurse practitioners, psychologists, psychology assistants, counselors, social workers, chemical dependency counselors, and students in training at the practice.) With appropriate releases, we may disclose your information to other clinicians outside *PBHS*, who may be involved in your care. For example, upon your request, we may provide your primary care physician with information regarding psychotropic medications that a *PBHS* clinician has prescribed you.



### **Payment**

Your health information may be used and disclosed so that the services you receive can be billed and paid by you, your insurance company, or other third parties. For example, we may provide information regarding the care you have been provided so that your insurance company can authorize payment and reimburse for services. We may also tell your health plan about a treatment you will receive so we can get prior authorization/approval or learn if your plan will pay for the treatment.

### **Health Care Operations**

*PBHS* may use your health information and disclose it outside of our practice for health care operations. These uses are for the purpose of maintaining and improving our services. We may use data from groups of patients to evaluate the efficacy of our programs and measure the performance of our staff. We may also remove information that identifies you to use the data in studying treatment efficacy and other factors in the delivery of behavioral health care.

### **Contacting you**

We may use and disclose health information to reach you about your appointments and other matters. We may contact you by mail, telephone, or email. For example, we may leave voice messages at the telephone number you provided us with, and we may respond to your email address. If there are any of these methods that you do not want to be used, please notify us at the time of your registration as a patient/client at *PBHS*.

### **Health Information Exchanges**

We may participate in certain health information exchanges to disclose your health information, as permitted by law, to other healthcare providers or entities for treatment. These entities may include specialists involved in your care or agencies that may have referred you to us. You will be requested to authorize *PBHS* to provide this information and sign appropriate forms.

### **Organized Health Care Agreements**

*PBHS* may participate in joint arrangements with other healthcare providers or healthcare entities whereby we may use or disclose your health information, as permitted by law in joint activities involving treatment, review of healthcare decisions, quality assessment, and/or payment activities.



### **Psychiatric and Psychological Research**

*PBHS* is a learning organization, and at times, we conduct research that may involve evaluating the outcome of services or another related topic that could include your health information. All research conducted at *PBHS* is evaluated and approved by a clinical leadership committee consisting of the Medical Director and the Clinical Director to ensure that it meets appropriate standards of practice, including privacy. We will not use your health information without your approval and maintain that your privacy is protected.

### **Organ and Tissue Donation**

We may release health information about organ, tissue, and eye donors and transplant recipients to organizations that manage organ, tissue, and eye donations and transplantation.

### **Public Health and Safety**

*PBHS* will disclose health information about you outside of *PBHS* when required to do so by federal, state, or local law or under a court order. We may provide health information about you for public health and safety reasons, like reporting child abuse or neglect, reaction to medications, or problems with medications. We may release health information to help control the spread of disease or notify a person whose health or safety may be threatened. We may also disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure and accreditation. We may disclose health information about you in the event of an emergency or for disaster relief purposes.

### **Authorization for Other Uses and Disclosures**

As described above, we will use your health information and disclose it outside *PBHS* for treatment, payment, health care operations, and when required or permitted by law. *PBHS* will not use or disclose your health information for other reasons without your written consent and authorization. For example, most uses, and disclosures of psychotherapy notes, uses and disclosures of health information for specific marketing purposes, and disclosures that constitute a sale of health information require your written authorization. *PBHS* will make these kinds of uses and disclosures of your health information only with your written authorization. You may revoke the authorization in writing at any time, but we cannot take back any uses or disclosures of your health information already made with your permission.

Federal law may require that we obtain your consent for specific disclosure of health information about the followings: the performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition, genetic test results, drug or alcohol treatment that you have received as part of a drug or alcohol treatment program.



## **YOUR RIGHTS REGARDING HEALTH INFORMATION**

### **Right of Accounting**

You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom *PBHS* has disclosed your health information without your written authorization. The account would not include disclosures for treatment, payment, healthcare operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures needs to be in writing, signed, and dated. It must identify the time period of disclosure and *PBHS*, which is the holder of the records. We will not list disclosures made earlier than six years before your request.

Your request should indicate the method in which you request the list (for example, on paper or electronically). The request needs to be in writing and submitted to *PBHS* to the attention of:

Premier Behavioral Health Services  
Attn: Medical Records  
8701 Mentor Avenue  
Mentor, Ohio 44060

### **Right to Amend**

If you feel that the health information we have about you is incorrect or incomplete, you have the right to ask us to amend your medical records. Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend and provide the reason for your request. We may deny your request; if we do, we will inform you why and explain your options. *PBHS* will respond to you within 60 days. Please submit your request to:

Premier Behavioral Health Services  
Attn: Medical Records  
8701 Mentor Avenue  
Mentor, Ohio 44060

### **Right to Inspect and Obtain a Copy**

You have the right to inspect and obtain a copy of your completed health records unless your provider believes that disclosing that information to you could harm you. You may not see or get a copy of the information gathered for a legal proceeding. Your request to inspect or obtain a copy of your records must be submitted in writing, signed, and dated. We may charge you a fee, based on our cost, for processing your request. (continued on next page)



(Right to Inspect and Obtain a Copy continued)

If *PBHS* denies your request to inspect or obtain a copy of your records, you may appeal the denial in writing to:

Premier Behavioral Health Services  
Attn: Clinical Director  
8701 Mentor Avenue  
Mentor, Ohio 44060

### **Right to Request Restrictions**

You have the right to ask *PBHS* to restrict the uses or disclosures we make of your health information for treatment, payment, or health care operations, but we do not have to agree in some circumstances. However, if you pay out-of-pocket and in full for services you receive, and you ask us to restrict the disclosure to a health plan of your health information relating solely to that service, we will agree to the extent that the disclosure to the health plan is to carry out payment or healthcare operations and the disclosure is not required by law. You may also ask us to limit the health information that we use or disclose about you to someone involved in your care or the payment for your care, such as a family member or friend. Again, we do not have to agree. The request for a restriction must be signed and dated. The request should also describe the information you want to be restricted if you wish to limit the use or the disclosure of the information or both and tell us who should not receive the restricted information. You must submit the request in writing to *PBHS*. We will notify you if we agree with your request or not. If we agree, we will comply with your request unless this information is needed to provide you with emergency treatment. Please submit your request to:

Premier Behavioral Health Services  
Attn: Clinical Director & Medical Records  
8701 Mentor Avenue  
Mentor, Ohio 44060

### **Right to Request Confidential Communications**

You have the right to request that we communicate with you about your health in a certain way or at a specific location. For example, you can ask that we only contact you at work or by mail. Your request for confidential communications must be in writing signed and dated. It must also specify how or where you wish to be contacted. You do not need to tell us the reason for your request, and we will not ask. You must send your written request to *PBHS*. (continued on next page)



(Right to Request Confidential Communications continued)

We will accommodate all reasonable requests. Please submit your request to:

Premier Behavioral Health Services  
Attn: Medical Records  
8701 Mentor Avenue  
Mentor, Ohio 44060

### **Right to a Paper Copy of This Notice**

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to the paper copy. You may obtain a paper copy of this Notice at *PBHS* or print it from our website at <https://pbhsohio.com>.

### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with *PBHS'* Compliance Officer or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with *PBHS*, you must submit your complaint in writing to the Compliance Officer of *PBHS*. You will not be penalized for filing a complaint. Please submit your request to:

Premier Behavioral Health Services  
Attn: Compliance Officer  
8701 Mentor Avenue  
Mentor, Ohio 44060

### **CHANGES TO THIS NOTICE**

*PBHS* may change this Privacy Practice Notice at any time. Any changes in the Notice could apply to health information we already have about you and any information we receive in the future. We will post a copy of the most current Notice on our website at <https://pbhsohio.com>.

### **QUESTIONS**

If you have any questions about this Privacy Practice Notice, you may call *PBHS* at (440) 266-0770 and ask to speak with the Compliance Officer.