**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**DEPARTMENT OF BEHAVIORAL HEALTH**
**JOINT NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW THE DEPARTMENT OF BEHAVIORAL HEALTH MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI), AND HOW YOU CAN ACCESS YOUR PHI. PLEASE REVIEW THIS NOTICE CAREFULLY.**

The Department of Behavioral Health (DBH) and its network providers must keep your medical, mental and substance use disorder treatment information, also known as Protected Health Information (PHI), confidential.

Your PHI is any record that can identify you and relates to your health care. Your PHI can include records like your name, address, birth date, phone number, social security number, Medicaid or Medicare number, health insurance policy information, and information about your health condition or care.

## 1. OUR DUTY TO PROTECT YOUR PHI

The law requires DBH and its network providers to keep your PHI private. We must provide you this Notice of our legal duties and privacy practices, which explains how your PHI will be used, shared and protected. The law requires DBH and its network providers to abide by this Notice.

## 2. USE OF YOUR PHI

We may use your PHI for treatment, payment, and other permitted purposes. We allow DBH personnel to process payment for your medical, mental health and substance use treatment with your PHI. We also allow DBH personnel access to your PHI as necessary to review the quality of care you receive, review provider certification and licensure, and to conduct audits.

We may also use and/or disclose your PHI without your permission when permitted by law. Please note that different sets of laws govern the confidentiality of your substance use treatment records and your medical/mental health records. Information about how your records can be shared is detailed below.

We may disclose your **medical and mental health PHI** without your permission:

1. With other healthcare providers or District Health and Human Services Agencies and their contractors (including the Department of Human Services, the Child and Family Services Agency, DC Health, and the Department of Health Care Finance) to coordinate your treatment, benefits, and services. You may opt-out of granting DBH the right to share your PHI with providers **outside** of the DBH network and the District Health and Human Services cluster. “Opt-out” means that you do not want your provider to share your PHI with outside providers unless you have signed a release authorizing disclosure or we are legally obligated to share your PHI (i.e. DBH may be legally obligated to share your PHI during a medical emergency or in response to a court order).
2. To submit claims for services delivered to you.
3. For public health activities such as reporting suspected child abuse or neglect or to prevent or control disease.
4. If DBH or its network provider reasonably believes that you are the victim of abuse, neglect, or domestic violence, we may share your PHI with a social services or law enforcement agency.

5. For oversight activities like audits; investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions.
6. In response to an order of a court or administrative tribunal, or a subpoena.
7. To law enforcement officials in response to a warrant, subpoena or an administrative request; to identify or locate a suspect, fugitive, witness, or missing person; or to report actual or threatened criminal conduct, including those occurring on the premises of DBH or a network provider.
8. In a medical or psychiatric emergency when your health requires immediate medical attention.
9. For research purposes if the research study meets certain privacy requirements.
10. To prevent a serious or imminent threat to public health and safety.
11. When requested by a representative from a Protection and Advocacy Agency for the District of Columbia as part of an investigating into alleged abuse or neglect of a person with mental illness.
12. To correctional institutions having lawful custody of you to coordinate your treatment or care, and when needed to ensure the health and safety of other inmates and staff.
13. To monitor your compliance with a condition of pretrial release, probation, parole, supervised release, or diversion agreement regarding mental health treatment.
14. Pursuant to a qualified service organization or business associate agreement.

In addition, we may disclose your **substance use treatment PHI** without your permission **only**:

1. In medical emergencies when we cannot obtain your written consent.
2. For research purposes, if the research study meets certain privacy requirements.
3. For audits and evaluations of the substance use treatment program.
4. With a valid court order.
5. To report suspected child abuse and neglect.
6. To law enforcement to report a crime that occurred on the premises of a substance use provider.
7. To a qualified services organization to provide services to the substance use treatment program.

You may choose to share your PHI with a specific person, business or organization for purposes other than those described above (for instance, you may want to share your PHI with your attorney). If you would like to do so, you must sign a Release of Information to allow DBH to share your PHI.

## 3. PARTICIPATION IN THE DISTRICT OF COLUMBIA HEALTH INFORMATION EXCHANGE

It is DBH policy to encourage the timely coordination of care between a consumer/client's treating health and behavioral health providers to improve overall health and wellness. An HIE is a system that enables the secure electronic exchange of health information across multiple organizations. HIEs allow you and your health care professionals to appropriately access and securely share your medical information electronically, while ensuring that your PHI is protected. The Chesapeake Regional Information System for Our Patients, Inc. (CRISP DC) has been selected as the District's designated HIE.

Through this relationship, DBH and its provider network participate in CRISP DC. As permitted by federal and D.C. privacy laws, your health information will be shared with CRISP DC to provide faster access, better care coordination, and to assist providers and public health officials in making more informed decisions about your care. Unauthorized disclosures of mental health information are prohibited pursuant to the District of Columbia Mental Health Information Act of 1978 (§§7-1201.01 to 7-1207.02). Part 2 of Title 42 of the Code of Federal Regulations (42 C.F.R. Part 2) prohibits unauthorized disclosure of substance use disorder patient records.

If you are receiving **mental health treatment services**, you will be registered in CRISP DC unless you **opt-out** of participating. If you do not want your information shared in this way, you can opt-out by completing a written opt-out form and providing it to DBH at any time to submit to CRISP DC, by calling (877) 952-7477, or by completing and submitting an opt-out form to CRISP DC by mail, fax or through the CRISP DC website at

www.crispdc.org, including information on CRISP DC's record sharing policies. The opt-out will not affect any action by CRISP DC before it was received. CRISP DC will comply with opt out requests to the extent required by applicable federal and D.C. privacy laws. Please visit www.crispdc.org and click on 'For Patients' to see more information.

If you are receiving **substance use treatment services**, you must choose to **opt-in** to participate in the CRISP DC HIE by completing the opt-in form and providing it to DBH at any time to submit to CRISP DC. DBH and its network providers will not share any of your substance use treatment information with CRISP DC without a written opt-in form from you.

## 4. AUTHORIZATION FOR OTHER USES AND DISCLOSURES OF PHI NOT MENTIONED IN THIS NOTICE

DBH and its provider network will only use or disclose your PHI for purposes addressed by this Notice. DBH and its provider network will never sell your PHI. DBH and its provider network will obtain your written authorization for other uses and disclosures. You may revoke your authorization in writing at any time. The revocation of your authorization will not affect any action taken by DBH or its provider network before the written revocation was received. You may contact the DBH Privacy Officer at the address listed at the end of this Notice for further information.

## 5. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI. In writing, you may:

1. Ask us to limit how your PHI is used or given out, including the right to opt-out of disclosures of your mental health information to providers outside of the DBH network and the District Health and Human Services cluster. We are not required to agree to your request. If we do agree, we will honor it;
2. You have the right to be informed about your PHI in a confidential manner that you choose. The manner you choose must be reasonable for us to do;
3. Generally, see and copy your PHI. You may ask that any refusal to do so be reviewed. You may be charged a reasonable fee for copies;
4. Ask DBH or a provider to change PHI in your record. We may not make your requested changes. If so, we will tell you why we cannot change your PHI. You may respond in writing to any denial. You may ask that both our denial and your response be added to your PHI;
5. Get a listing of certain entities that received your PHI from DBH after April 14, 2003. This list will not include a listing of disclosures made for treatment, payment, healthcare operations, information you authorized us to provide, or government functions;
6. Restrict disclosure of PHI when paid out of pocket;
7. Request a paper copy of this Notice of Privacy Practices; and
8. Be notified of a breach of your PHI.

## 6. YOUR RIGHTS REGARDING YOUR PHI

If you wish to exercise your rights, or you have a question or complaint about the use and disclosure of your PHI, **you should contact the privacy officer at the agency providing you treatment**. You may also contact the DBH Privacy Officer:

DBH Privacy Officer
Department of Behavioral Health
64 New York Avenue, NE, 3rd Floor
Washington, D.C. 20002
(202) 671-4088
TTY/TTD: (202) 673-7500
E-mail: dbh.privacy@dc.gov

You may also complain to the U.S. Department of Health and Human Services, by sending a written complaint to the following address:

Office for Civil Rights – Region III
U.S. Department of Health and Human Services
Centralized Case Management Operations
U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
Hotline (800) 368-1019

Please check https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html for more information on making a complaint to DHHS.

If you have access to a computer, you may submit a complaint form electronically using the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by e-mail: OCRComplaint@hhs.gov

You always have the right to file a grievance through the DBH grievance procedures. Please refer to DBH Policy 515.3, Consumer Rights for further information about how to file a grievance. Please note that no one may take any action against you for complaining about the use and disclosure of your PHI.

If you have a hard time understanding this Notice, please ask for assistance.

## 7. CHANGES TO THIS NOTICE

If the law requires changes to the terms of this Notice, all network providers will be required to follow the terms of the changed Notice. If the Notice is changed, the changes will apply to all PHI (including medical information, mental health information, and alcohol/drug treatment and prevention information maintained by an alcohol/drug treatment and prevention provider) created or received before the Notice was changed. The amended Notice will be posted on the DBH website and should be provided to you at your next visit and posted at all service sites.

**ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF JOINT PRIVACY PRACTICES**

I acknowledge that I have been offered a copy of the DBH Provider Network's Joint Notice of Privacy Practices.

Signature_____________________________________________ Date _______________________

Please Print Name__________________________________________________________________

Relationship if other than consumer______________________________________________________

________ I refuse to sign this form.

**1. FOR MENTAL HEALTH CONSUMERS ONLY**

________ I opt-out of participating in CRISP DC and sharing my PHI with my health care and mental health care providers outside of the DBH Network. I understand that opting-out does not affect my DBH provider's authority to disclose my mental health information without a release under the D.C. Mental Health Information Act under the circumstances described in Section 2 of the Joint Notice of Privacy Practices.

**2. FOR SUBSTANCE USE CLIENTS ONLY**

________ I opt-in to participating in CRISP DC and sharing my PHI with my health care and mental health care providers outside of the DBH Network.

I voluntarily authorize and request disclosure of my past, present, and future clinical records, including my substance use records, from DBH/network provider to CRISP DC in order to participate in the HIE. The information shared will be used to help my health care team coordinate my care and provide health care treatment. I understand that CRISP DC will provide my clinical records, including my substance use records, to any of my past, present or future providers that participate in the CRISP DC HIE. For a list of providers that participate in the CRISP DC HIE, I can go to www.crispdc.org.

I would like to share the following information with CRISP DC (Please select one):

________All of my substance use treatment information (this may include, but is not limited to, treatment plans, medications, lab results, and progress notes).

________Only my substance use treatment provider's name and contact information.

I understand that I may revoke this authorization at any time by giving written notice to the organization that was authorized to release my information. I understand that revocation of this authorization will not affect any action taken by the organization that was authorized to release this information before it received my written revocation.

This authorization will expire 365 days from the date this form was signed. If you wish for this authorization to expire sooner, please provide the date on which this authorization will expire:________________________________________

By signing below, I acknowledge that I have the legal authority to consent to share the named individual's substance use disorder treatment information. I acknowledge that I have read this form and understand that my substance use disorder treatment information may be shared with CRISP DC who may then share it with members of my health care team who participate with CRISP DC.

**Signature of Client**

_______________________________________________ _______________________________________
Signature Date

**Signature of Client's Parent/Legal Guardian/Personal Representative (if applicable)**

_______________________________________________ _______________________________________
Signature Date

_______________________________________________ _______________________________________
Printed Name Relationship to Client

## 3. PROVIDER VERIFICATION OF CONSUMER/CLIENT OR PERSONAL REPRESENTATIVE IDENTITY

I verified the identity of the consumer/client/personal representative by________________________________

_______________________________________________ _______________________________________
Signature Date

_______________________________________________ _______________________________________
Printed Name Title

## 4. NOTE TO NETWORK PERSONNEL

If consumer/client/representative refuses the Notice or to sign the Acknowledgement, please acknowledge the refusal by providing the following information:

Network Personnel's Name: _________________________________________________________________

Title: ____________________________________________________________________________________

Signature_________________________________________________ Date ___________________________

Comments:________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Joint Notice of Privacy Practices & copy of Acknowledgement Form – Consumer
Original Acknowledgement Form – Clinical Record