PROJECT TRANSITION
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFROMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Project Transition is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our members with notice of our legal duties and privacy practices with respect to your protected health information.

Please also note that any release of protected health information must be in compliance with the federal Privacy Act (PL92-282), Federal Confidentiality rules (42 CRF, part2), the PA Mental Health Procedures Act and 4 PA Code Section 255.5 relative to the release of drug and alcohol treatment information. Your health information is also protected from further re-disclosure from those receiving it according to the rules and statues noted above.

Disclosure of Your Health Care Information

Treatment

With your written consent, we may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.
(Examples)

> *"On occasion it may be necessary to seek consultation regarding our condition from other healthcare providers associated with Project Transition."*
>
> *"It is our policy to provide a substitute healthcare provider, authorized by Project Transition, to provide assessment and/or treatment to our members, without advance notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situation."*

Payment

With your written consent, we may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.
(Example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Project Transition for healthcare services rendered. If you pay for your healthcare services personally, we will (as a courtesy) provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing*

statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation
With your written consent, we may disclose your health information as necessary to comply with State Workers' Compensation Laws.

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

Public Health
As required by law, we may disclose your health information to public health authorities for 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.

Judicial and Administrative Proceedings
With your written consent, we may disclose your health information in the course of any administrative or judicial proceedings. Only upon receipt of a verified good cause court order may we release protected health information. In cases of drug and alcohol treatment that information is limited to: attendance at the program, a brief description of your progress, your prognosis, the nature of our program, and weather there has been a relapse along with the frequency of relapse.

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 subject to the limitations noted in the section above.

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

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

Research
We may disclose certain non-identifying pieces of 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 lesson a serious and imminent threat to the health or safety of a particular person or to the general public.

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

Change of Ownership
In the event that Project Transition is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information.
- You have the right to revoke any authorizations for release by verbal or written dated communication in our office.
- You have the right to have your health information received or communicated through an alternative method or send 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 the right to request that Project Transition amend your protected health information. Please be advised, however, that Project Transition 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 or our denial reason(s) and informed about how you and disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by Project Transition.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Subject to State and Federal Law, Project Transition 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. Until such amendment is made, Project Transition is required by law to comply with this Notice.

Project Transition 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. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Paul Keisling by calling this office at 215-997-9959. If Paul Keisling is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how Project Transition has handled your health information should be directed to Paul Keisling by calling this office at 215-997-9959. If Paul Keisling 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 _____/_____/_____

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

By way of my signature, I certify that I understand how Project Transition, with my prior written authorization and consent, will use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Members Name (Print)

_____ _____
Members Signature Date

_____ _____
Authorized Facility Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
PROJECT TRANSITION

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Project Transition's "NOTICE OF PRIVACY PRACTICES," revision date _____.

As required by the Privacy Regulations, _____ from
Name of staff member
Project Transition has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that Project Transition has included a provision that it reserves the right to change the terms of its notice and to make the new provisions effective for all protected health information that it maintains.

Requests:

☐ I wish to file a "Request for Restriction" of my Protected Health Information.

☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

☐ I wish to object to the following in the "Notice of Privacy Practices".

_____

_____

I understand that this office may not be required to honor some changes to the "Notice of Privacy Practices."

_____ _____
Signature Date

_____
Printed Name

_____
(Office use only)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt (Describe)_____