FAMILY SOLUTIONS SERVICES, INC.

Orange City Office: 712-707-9222
1217 Hwy 10 W., PO Box 258

Cherokee Office: 712-707-9222
795 N. 2nd St.

Le Mars Office: 712-707-9222
19 2nd Ave. NW

Sioux City Office: 712-258-4553
2910 Hamilton Blvd. Lower A

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and also how you can get access to this information. Please review it carefully, and if you have any questions, ask your therapist. If the client is a minor child, in most cases, the child's parent(s)/legal guardian(s) are the personal representatives for a minor child, and can exercise their individual rights on behalf of the child. However, in certain cases, neither parent is considered the personal representative. If the Iowa Department of Human Services, or Human Services from another state, or the courts do not permit parental involvement and access, then a personal representative, legally authorized to make health care decisions on the child's behalf who is in good standing may be involved.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by our agency staff and others outside of our agency that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the agency's practice, and any other use required by law.

1. TREATMENT:

We may use and disclose your protected health information to provide, coordinate or manage your health care and any related services without consent or authorization unless otherwise required by law or in those situations limited in our confidentiality policies and procedures, a copy which will be given to you at time of admission or intake. This includes the coordination or management of your health care with a third party.

2. PAYMENT:

Your protected health information will be used, as needed, to obtain payment from other sources for your health care services.

3. HEALTH CARE OPERATIONS:

We may use or disclose your protected health information without your authorization, in the following situations, including but not limited to:

1) those as required by state and federal law or regulation,
2) public health activities as required by law and rule,
3) Iowa department of human services activities as required by law and rule,
4) health oversight, including monitoring of communicable diseases,
5) reporting abuse, neglect or domestic violence,
6) food and drug administration requirements,
7) as required by judicial and administrative proceedings,
8) law enforcement purposes,
9) purposes related to coroners, medical examiners or funeral directors,
10) during times of serious threat to health or safety,
11) national security activities authorized by law,
12) determining eligibility or conducting enrollment in certain government benefit programs, and
13) when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with HIPAA requirements (Section 164.500).
14) Insurance Functions,

15) Business planning development and Administration,
16) Quality assessment and improvement activities, including case management and care coordination,
17) Competency assurance activities, including provider evaluation, credentialing or accreditation,
18) Conducting or arranging for reviews, audits or legal services, including fraud and abuse detection, and compliance programs
19) Business management and general administrative activities, including but not limited to, de-identifying protected health information, employee review activities, training of student interns, licensing, certification and contracting, and conducting or arranging for other business activities.

4. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES:

Other permitted and required uses and disclosures will be made only with your authorization or opportunity to object, unless required by law. You may revoke this authorization at any time, in writing, except to the extent that our agency or others outside who are involved in your care have taken an action in reliance on the use or disclosure indicated in the authorization.

5. YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

1) You have the right to inspect per our agency's policies and procedures as outlined in the Informed Consent.
2) You have the right to request a restriction or limitation on the use of your protected health information, per our agency's policies and procedures.
3) You have the right to request to receive confidential communication from us by alternative means or at an alternative location.
4) You have the right to obtain a paper copy of this notice from us.
5) You may have the right to request an amendment to records of your protected health information.
6) You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

6. COMPLAINTS:

You will not be retaliated against for filing a complaint. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Director(s) of Family Solutions Services 1, Inc., Denise Driesen 712-541-0107 or Nichole Hanks at 712-898-1245. You may also file a complaint with the Secretary of Health and Human Services by notifying Health and Human Services at 200 Independence Avenue, SW, Washington, D.C. 20201 or by calling (202) 619-0257 or toll free 1-877-696-6775.

Further information on HIPAA requirements for smaller agencies and related HIPAA information can be found electronically at http://www.hhs.gov/ocr/hipaa/smallbusiness.html

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HIPAA CONSENT SIGNATURE:

The attached *HIPAA Notice of Privacy Practice* form for Family Solutions Services 1, Inc. has been made available to our family and the form has been read. We understand our rights as a client of Family Solutions Services 1, Inc. and have been given a copy of the *HIPAA Notice of Privacy Practice,* if requested.

Signature of Client or Legal Guardian:_____ Date:_____

Witness Signature:_____ Date:_____

This agreement terminates upon termination of services unless otherwise requested in writing by the client or legal guardian.