easterseals
Capital Region & Eastern Connecticut

Confidentiality, Privacy, and Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read this carefully.

Name: DOB: Date:

In the course of your care and treatment by this organization, we will gain information about you, including demographic data relating to your past, present or future physical or mental health or condition, your health care services, and a payment of the provision of your health care. To the extent that this information is identifiable as relating to you individually, this is PHI or protected health information.

As an entity covered by the HIPAA Privacy Law, we may not use or disclose your PHI except as permitted or required by the Privacy Rule or as you authorize in writing. We are required to disclose your PHI to you (or your authorized personal representative) when you specifically request access to your PHI or an accounting of disclosures of your PHI, and to the U.S. Department of Health and Human Services when it undertakes a compliance investigation or review or enforcement action.

We are permitted to use and disclose PHI **without your authorization** for treatment, payment and health care operations as well as those uses and disclosures required by law. Treatment relates to healthcare you receive and the sharing of information among health care providers involved in your care. Payment pertains to sharing information with your insurance company including Medicaid and Medicare and any other entity authorized by you to obtain payment for services rendered to you. Health care operations include the management of care provided at our facility such as monitoring quality of care. Uses and disclosures required by law include: (1) circumstances defined by statute, regulations, or court orders; (2) public health activities; (3) disclosures pertaining to suspected abuse, neglect, or domestic violence; (4) health oversight activities (typically performed by the state of federal governments); (5) judicial and administrative proceedings; (6) law enforcement purposes; (7) decedents (for example, to coroners or funeral directors); (8) post-mortem organ or tissue donation; (9) appropriately authorized research; (10) in the event of a perceived serious threat to health or safety; (11) for essential government services; and (12) for workers compensation claims.

You have the right to request restrictions on the uses or disclosures of PHI for treatment, payment, or health care operations, disclosure to persons involved in your health care or its payment, or disclosure to notify family members or others about your general condition, location, or death. Easterseals is not obliged to agree to these restrictions, however if it does agree to such restrictions it will comply with them except for purposes of treating you in a medical emergency,

If you have paid for health care services in full out of pocket; you have the right to restrict disclosure of related PHI to health plans otherwise involved in your treatment or payment for your health care and we will not refuse to honor such requests.

We may use your PHI for the purpose of keeping you informed of activities of this organization and for fundraising purposes. You have the right to opt out of receiving further such communications upon written request.

For other uses and disclosures; it is our policy to obtain your written authorization. All authorizations must be in writing in plain language, and including specific terms regarding the information to be disclosed. Or used the person(s) disclosing and receiving the information the expiration date of the authorization your right to revoke in writing and other relevant data and even after granting consent you can revoke the consent in writing except to the extent that the company has already taken prior action.

To be signed by either the client, patient or such party as may legally authorized to sign on the individual's behalf.

By my signature below, I acknowledge that (1) an Easterseals staff member has provided me with a copy of this privacy notice; (2) an Easterseals staff members has reviewed the provisions of this policy in a manner understandable to me; (3) I do fully understand the provisions of this notice and the company's privacy policies and procedures; and (4) I do fully accept and agree to the terms and conditions established through this notice and the company's policies and procedures.

Name of Client/Patient	*Signature*	*Date*

Under my authority as a: _____ Parent _____ Guardian _____ Conservator, I am legally authorized to act on behalf of: _____. By my signature below, I do hereby acknowledge on behalf of this individual that (1) Easterseals staff member has provided me with a copy of this privacy notice; (2) an Easterseals staff member has reviewed the provisions of this policy in a manner understandable to me; (3) I do fully understand the provisions of this notice and the company's privacy policies and procedures; and (4) I do fully accept and agree to the terms and conditions established through this notice and the company's policies and procedures.

Name of Legal Representative	*Signature*	*Date*

To be signed by the Easterseals staff member that reviews the notice and witnesses the signature of the client/patient or his/her representative

Name of Easterseals Staff Member	Signature	Date

Medical Services & Administration • *100 Deerfield Rd., Windsor, CT 06095* • *860-270-0600*
Vocational & Veterans Services • *22 Prestige Park Circle, East Hartford, CT 06108* • *860-728-1061*
Veterans & Adult Day Services • *24 Stott Avenue, Norwich, CT 06360* • *860-859-4148*