NOTICE OF PRIVACY PRACTICES

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

Effective Date: April 14, 2003. (revised April 2007, September 2013, March 2014)

We respect client confidentiality and only release medical information about you in accordance with the Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by Cornerstone Services, Inc.

Privacy Contact. If you have any questions about this policy or your rights, contact the Compliance and Quality Assurance Analyst/Privacy Officer at 815/741-7081.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you with services, there are times when we will need to share your medical information with others beyond our agency. This includes for:

Treatment. We may use or disclose medical information about you to provide, coordinate, or manage your services, including sharing information with others outside our agency that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This may include contacting your health insurance company for prior approval of planned treatment or for billing purposes. If you elect to pay out of pocket for your care, you may request that information about care that you paid for not be shared with your health insurance company.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your plan for services, and training staff.

Information Disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointment/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors, and Organ Donation. We may disclose medical information to a coroner or medical examiner and funeral directors for the purpose of carrying out their duties. When organs are donated sufficient information will be provided to the program as necessary to facilitate the organ or tissue donation.

Next of Kin and Emergency Contacts We may disclose relevant information to your next of kin or emergency contact after your death in the under the same circumstances that where permitted when you were alive.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, accreditation and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

Fundraising. As a not-for-profit provider of health care services we need assistance in raising money to carry out our mission. We may contact you to seek a donation.

Marketing Communication/Sale of Protected Health Information (PHI) We will not market products to you and we will never sell your PHI.

CLIENT RIGHTS

You have the following rights under Illinois and federal law:

Copy of Record. You are entitled to inspect the record our agency has generated about you. We may charge you a reasonable fee for copying and mailing your record. You have the right to request your records be delivered to you in an electric format (e-PHI) providing the agency has the capability to produce the records in that way. If a mutually agreed upon media cannot be obtained then records will be made available as hard copies. You can request that information be e-mailed to you; however you are also advised that sending documents in this fashion (even if encrypted) can put your PHI at risk.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge about your services. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the medical information. This request must be in writing. We are not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the **Privacy Contact.**

Contacting You. You must request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. We also will be glad to provide you information by email if you request it. If you wish us to communicate by email you are also entitled to a paper copy of this privacy notice.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the **Privacy Contact** and ask for the *Request to Amend Health* Information form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement indicating you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your medical information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. This also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to our **Privacy Contact.** We will notify you of the cost involved in preparing this list.

Breach Notification You will be notified in the unlikely event that your PHI confidentiality has been breached. Breaches will be handled in the manner forth in the HIPAA act as well as the HITECH act.

Questions and Complaints. If you have any questions, or wish a copy of this policy or have any complaints you may contact our **Privacy Contact** in writing at our office for further information. You also may complain to the U.S. Department of Health and Human Services, Office of Civil Rights, if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. Cornerstone Services reserves the right to change its Privacy Policy based on the needs of the agency and changes in state and federal law.

CORNERSTONE SERVICES

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Cornerstone and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Cornerstone. I authorize Cornerstone to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Cornerstone may release objective clinical information related to my diagnoses and treatment which may be requested by my insurance company or its designated agent. (_____)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I authorize payment to be made directly to Cornerstone for insurance benefits payable to me. I understand that I am financially responsible to Cornerstone for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorneys fees. (_____)

PRIVACY POLICY. I acknowledge having received Cornerstone's "Notice of Privacy Practices". My rights including the right to see and copy my record, to limit the disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent that Cornerstone has already made disclosures with my prior consent. (_____)

_____ _____ _____

Patient or Authorized Person Signature Relationship Date

_____ _____

Witness Signature Date

Patient unable to sign. Verbal consent given. Reason: _____

Revised 3/2014