



Notice of Privacy Practices

The Alliance for Positive Health Inc. is committed to protecting and preserving your privacy. This notice outlines how we protect your information and what information may be used and disclosed while you are receiving services from us. It also details your rights regarding your personal health information (PHI).

General Information

Information regarding your health care, including payment for health care, is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any HIV-related information is also protected by New York law, Article 27-F of the Public Health Law ("Article 27-F"). Under these laws, the Alliance for Positive Health ("Alliance for Positive Health") may not disclose any health-related information about you except as permitted by both laws.

What Health Information is Protected

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information include information indicating that you are receiving health-related services from our agency, information about your health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information, such as your name, address, Social Security number or phone number.

We will only share your information with those who need to know and are allowed to see the information to assure quality services to you. All people who work for us in any programs directly operated by us will follow this notice. This includes all our employees and volunteers who may assist you. In addition, contractors, agencies, and other organizations that provide services on our behalf, and who are authorized to access your records, and have agreed to protect your information, will follow this notice.

Our Responsibilities for Your Information

The Alliance for Positive Health is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our agency. You will also be able to obtain a copy by accessing our website at www.allianceforpositivehealth.org or calling the Privacy Officer (Director of Grants Management) at 518-434-4686.

The Alliance for Positive Health has the right to change this Notice of Privacy Practices as well as our privacy policies and procedures as business needs change and federal and state law require. If we make a significant change to the privacy practices in this notice, we will send a new notice of Privacy Practices to you within 60 days of the change. Except as required by law, we will not put into practice a significant change to any part of this notice before the effective date of the new notice.

If you have any questions about this notice or would like further information, please contact the above referenced individual.

Your Rights

Under HIPAA, you have the following rights to access and control your health information:

1. Right To Inspect And Copy Records
2. Right To Amend Records
3. Right To An Accounting Of Disclosures
4. Right to Receive Notification of a Breach
5. Right To Request Restrictions
6. Right To Request Confidential Communications
7. Right To Have Someone Act On Your Behalf
8. Right To Obtain A Copy Of Notices
9. Right To File A Complaint
10. Use and Disclosures Where Special Protections May Apply

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

1. Among our own staff in accordance with our written protocol
2. To the State Department of Health for public health monitoring and partner notification
3. To appropriate authorities when relevant to report suspected child or elder abuse or neglect
4. For treatment, payment and health care operations
5. For appointment reminders, treatment alternatives, benefits and services
6. To Business Associates
7. To friends and family designated to be involved in your care
8. For emergencies or public need
9. When information is completely or partially de-identified

For a complete explanation of when we can disclose information without your permission, please ask the staff person providing you services.

Complaints and Reporting Violations

You may complain to us and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. You may file a complaint with us by notifying the Director of Grants Management (Privacy Officer) of your complaint. You will not be retaliated against for filing such a complaint. The Director of Grants Management may be contacted in writing at P.O. Box 10201, Albany, New York, 12202 or by telephone at (518) 434-4686.

If you believe your rights have been violated under Article 27-F (which protects the confidentiality of HIV related information about you), you may file a complaint with the New York State Department of Health and/or file a lawsuit. The Health Department's AIDS Institute has a special unit that takes Article 27-F complaints. Their HIV Confidentiality Hotline is 800-962-5065. The Department of Health may impose a fine of up to \$5,000 per violation. Criminal penalties may be imposed if the violation was "willful."

Contact

For further information, contact the Privacy Officer (Director of Grants Management) at (518) 434-4686.

Acknowledgement and Consent

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the agency listed at the beginning of this notice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information from my health care provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the agency, its staff, and its business associates.

Signature of Individual or Personal Representative

Print Name of Individual or Personal Representative

Date