

NOTICE OF PRIVACY PRACTICES: Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of SAY San Diego, Inc. ("SAY"). Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at <http://www.saysandiego.org> or on request from your health care team.

I acknowledge receipt of the Notice of Privacy Practices of SAY.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

Reasons why the acknowledgement was not obtained:

- Patient refused to sign.
- Other or Comments:

NOTICE OF PRIVACY PRACTICES

SAY SAN DIEGO, INC.

Effective Date: **February 1, 2009**

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.

WHO WILL FOLLOW THIS NOTICE

This Notice describes SAY San Diego, Inc.'s practices and that of:

- All employees, staff and other SAY personnel.
- Any member of a volunteer group we allow to help you while you are at SAY.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at SAY. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the facility. As required and when appropriate, we will ensure that only the minimum necessary information is released in the course of our duties.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations regarding the use and disclosure of medical information.

We are required by law to:

- Keep your medical information, also known as "protected health information" or "PHI," private;
- Give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We create a record of the treatment and services you receive at SAY. We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to doctors, nurses, technicians, or other facility personnel who are involved in taking care of you at SAY. For example, a doctor treating you for a chemical imbalance may need to know if you have problems with your heart because some medications affect your blood pressure. We may share your PHI in order to coordinate the different things you need, such as prescriptions, blood pressure checks and lab tests, and to determine a correct diagnosis.

We also may disclose your PHI to people outside the facility who may be involved in your treatment, such as your case manager, or other persons for coordination and management of your health care. Your mental health information may only be released to health care professionals outside this facility without your authorization if they are responsible for your physical or mental health care.

For Payment

We may use and disclose your PHI in order to get paid for the treatment and services we have provided you. For example, we may need to give your health plan information about a medication, visit, or treatment session you received at SAY so your health plan will pay us. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose your PHI to carry out activities that are necessary to run our facilities and to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Appointment Reminders

We may use and disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care at SAY.

Treatment Alternatives and Health-Related Products and Services

We may use and disclose your PHI to recommend possible treatment options or alternatives that may be of interest to you. Additionally, we may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities

We may use your PHI to contact you in an effort to raise money for SAY and its operations. If you do not want SAY to contact you for fundraising efforts, you must notify, the Director of Development; 8755 Aero

Dr. Suite 100, San Diego, CA 929123; 858-565-4148 and state that you do not want to receive further fundraising communications.

Individuals Involved in Your Care or Payment for Your Care

We may disclose your PHI to a friend or family member who is involved in your medical care or payment related to your health care, provided that you agree to this disclosure, or we give you an opportunity to object to this disclosure. However, if you are not available or are unable to agree or object, we will use our judgment to decide whether this disclosure is in your best interests.

Disaster Relief Purposes

We may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. We will give you the opportunity to agree to this disclosure or object to this disclosure, unless we decide that we need to disclose your PHI in order to respond to the emergency circumstances.

As Required By Law

We will disclose your PHI when required to do so by federal, state or local law.

To Avert a Serious Threat to Health and Safety

We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would be to someone able to help prevent the threat.

Workers' Compensation

We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose medical information about you for public health activities, such as those aimed at preventing or controlling disease, preventing injury or disability, and reporting the abuse or neglect of children, elders and dependent adults.

Military and Veterans

If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Health Oversight Activities

We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement

We may disclose PHI to government law enforcement agencies in response to a court order, warrant, subpoena, summons or similar process issued by a court.

Coroners, Medical Examiners and Funeral Directors

We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the facility to funeral directors as necessary to carry out their duties.

Specialized Government Functions

We may your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates

If you are an inmate of a correctional institution, you lose the rights outlined in this Notice. Furthermore, if you are an inmate or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Uses of Your Medical Information

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by the authorization, except that, we are unable to take back any

disclosures we have already made when the authorization was in effect, and we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI in our records:

Right to Inspect and Copy

With certain exceptions, you have the right to inspect and copy your PHI from our records. Usually, this includes medical and billing records.

To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing. A form will be provided to you for this request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied the right to inspect and copy your PHI in our records, you may request that the denial be reviewed. With the exception of a few circumstances that are not subject to review, another licensed health care professional within SAY, who was not involved in the denial, will review the decision to deny access. We will comply with the outcome of the review.

If your records are maintained in electronic format you have the right to request your copy in electronic form, or request that it is sent to another entity in electronic form.

Right to Request Amendment

If you feel that your PHI in our records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the PHI.

To request an amendment, you must submit your request in writing. A form will be provided to you for this request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend PHI that:

- Was not created by us, unless you can provide us with a reasonable basis to believe that the person or entity that created the PHI is no longer available to make the amendment;
- Is not part of the PHI kept by or for the facility;
- Is not part of the PHI which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a Statement of Disagreement, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want this form to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Breach Notification

If there is unauthorized access, review or viewing of your protected health information without a direct need for diagnosis, treatment or other lawful use as permitted by law; SAY must inform you of the breach within 5 days of SAY's discovery of the breach. If a large number of records are identified in the breach, SAY will post information on its website, along with a phone number to call to ascertain if your records were involved in the breach.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your PHI other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing. A form will be provided to you for this request. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to an accounting of disclosures that are made by a Business Associate of SAY.

If an electronic health record is used, you have the right to request an accounting of disclosures for treatment, payment and operational purposes for the 3 years preceding the request.

Right to Request Restrictions

You have the right to request that we follow additional, special restrictions when using or disclosing your PHI for treatment, payment or health care operations. You also have the right to request that we follow additional, special restrictions when using or disclosing your PHI to someone who is involved in your care or the payment for your health care, like a family member or friend. For example, you could ask that we not use or disclose that you are receiving services at SAY.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must submit your request in writing. A form will be provided to you for this request. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You have the right to request that SAY restrict the disclosure of protected health information to your health plan if: the protected health information refers solely to an item or service that has been paid for "out of pocket" in full.

Right to Request Confidential Communications

You have the right to request that we communicate with you about your appointments or other matters related to your treatment in a specific way or at a specific location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must submit your request in writing. A form will be provided to you for this request. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at our website: <http://www.saysandiego.org>

To obtain a paper copy of this Notice, please contact your health care team.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with SAY or the Federal Government. All complaints must be submitted in writing. **You will not be penalized or retaliated against for filing a complaint.** To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact:

SAY San Diego, Inc.

SAY Privacy Officer

8755 Aero Dr., Suite 100

San Diego, CA 92123

858-565-4148 ext. 221

To file a complaint with the Federal Government, contact:

Office of Civil Rights (Room 515 F)

US Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0805

(202) 619-0553