NOTICE OF PRIVACY PRACTICES

This notice describes how your protected health information (PHI) may be used and disclosed and how you can access this information.

Please review this notice carefully – the privacy of your PHI is important to us.

OUR LEGAL DUTY: We are required by applicable federal and state laws to maintain the privacy of your protected health information. Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), PHI is information that may identify you and that relates to your past, present, or future physical or mental health/condition and related health care services. We will not use or disclose PHI about you without your written authorization – except as described in this notice. We are required to give this notice about privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. In the event we make a material change in our privacy practice, we will change this notice and provide it to you.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose protected information about you for treatment, payment, and healthcare/program operations as follows:

1. **TREATMENT:** We may use or disclose your PHI to the referral source for purposes of treatment planning and coordination, reporting compliance/non-compliance issues, and referral to another additional service provider.
2. **PAYMENT:** We may use or disclose your PHI to obtain payment for services we provide to you. This may include such activities as verification of coverage and billing/collection activities and related data processing.
3. **HEALTHCARE/PROGRAM OPERATIONS:** We may use or disclose your PHI in connection with our healthcare program operations. This may include such activities as quality assessment and improvement activities, reviewing the competence and/or qualifications of healthcare/program professionals, evaluating provider performance, conducting training programs, and accreditation, certification, licensing and/or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your PHI for treatment, payment or healthcare/program operations you may give us written authorization to use your PHI or to disclose it for any purpose. If you give us an authorization, you may revoke it in writing at any time (except where required by court-ordered services). Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

REQUIRED BY LAW: We may use or disclose your PHI when we are required to do so by law – including judicial and administrative proceedings.

ABUSE OR NEGLECT: We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others – including, if report the ongoing abuse of a child, elderly person or person with a disability (vulnerable adult).

NATIONAL SECURITY: We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, or other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of PHI under certain circumstances.

APPOINTMENT REMINDERS AND TERMINATION NOTICES: We may use or disclose your PHI to provide you with appointment reminders or to advise you that you are at risk for program termination. Such activities may include voicemail messages and letters.

CONCERNS: If you believe your privacy rights have been violated, you may make a complaint by contacting Program Director or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

I have read and understand the above statements regarding Avante Treatment Centers Privacy Practices.

Client Print Name: ________________________________

Client Signature: ________________________________

Date: ________________________________

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 Avante Treatment Centers Representative: ________________________________

Date: ________________________________