

**CITIZENS, INC.**  
**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.**

**If you have any questions about this Notice please contact our Privacy Officer who is Anne Miller; Phone: (516) 293-1111 x 5477; E-mail: amiller@ahrc.org**

We understand that health information about you is personal. We are committed to protecting health information about you. We need to maintain certain information about you to provide you with quality services and comply with law and regulation. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, related health care services and payment for those services.

We are required to abide by the terms of this Notice of Privacy Practices. We are also required to notify you following a breach of unsecured health information. We may change the contents of our notice, at any time. The new notice will be effective for all protected health information that we maintain. You may obtain any revised Notice of Privacy Practices by accessing our website (citizens-inc.org), calling us and requesting that a revised copy be sent to you or asking for one when meeting with staff. We will promptly revise and make available this Notice whenever there is a material change to the uses or disclosures, your rights related thereto, our legal duties, or other privacy practices stated in this Notice.

**1. Uses and Disclosures of Protected Health Information**

**Uses and Disclosures of Protected Health Information  
Based Upon Your Written Consent**

You will be asked by Citizens, Inc. staff to sign a consent form. This document includes consent to the use and disclosure of your protected health information for treatment, payment and health care operations purposes, as described in this Section 1. Your protected health information may be used and disclosed by our staff and those outside of our Agency that are involved in your care and treatment for the purpose of providing services to you. Your protected health information may also be used and disclosed to bill your insurance and to support the operation of Citizens, Inc.

Following are examples of the types of uses and disclosures of your protected health care information that Citizens, Inc. is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our Agency.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your services. This includes the coordination or management of your services with a third party that has already obtained your permission to have access to your protected health information, such as another service provider. For example, we might disclose your protected health information, as necessary, to a physician that provides care to you or to your Medicaid Service Coordinator.

**Payment:** Your protected health information will be used, as needed, to obtain payment for services that we provide to you, such as: making a determination of eligibility or coverage for insurance benefits, and undertaking utilization review activities. For example, obtaining services may require that your relevant protected health information be disclosed to the health plan to obtain approval for Citizens, Inc. services. In addition, bills may be sent to you or third party payers, such as insurance companies or health plans. The information on the bill may contain information that identifies you, your diagnosis and services provided.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of Citizens, Inc. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health professionals and students, licensing, and conducting or arranging for other business activities. For example, we may use your information to evaluate the performance of staff involved in your care, to assess the quality of care you receive, and to learn how to improve our services.

We will share your protected health information with third party “business associates” that perform various activities for Citizens, Inc. Whenever an arrangement between our Agency and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose certain information about you in order to contact you for fundraising activities supported by Citizens, Inc. You have the right to opt out of receiving these materials. If you or your family do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent.

### **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Certain uses and disclosures require your authorization. An authorization is required, with certain exceptions, for any use or disclosure of your protected health information for marketing purposes or for purposes involving the sale of your protected health information. Also, a specific authorization is required for the release of HIV/AIDS, mental health, and psychotherapy notes and information.

Except as described in this Notice, uses and disclosures will be made with your written authorization. You may revoke such authorization, at any time, in writing, except to the extent that Citizens, Inc. has taken an action in reliance on the use or disclosure indicated in the authorization.

## **Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object**

We may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. In this regard, we will ask you to provide us with the names of persons to whom we may speak. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or passing. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

## **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required by Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of

abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, tract products; to enable product recalls; to make repairs or replacements, or to conduct post-marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process. Special rules apply for HIV/AIDS information and mental health information.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and as otherwise required by law, (2) limited information requests for identification and location purposes, (3) disclosures pertaining to victims of a crime, (4) where there is suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of Citizens, Inc., and (6) medical emergency (not on Citizens, Inc.'s premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donations purposes.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorize federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or other legally authorized.

**Workers' Compensation:** Your protected health information may be disclosed by us as to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 *et. seq.*

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you for as long as we maintain the protected health information.

We may charge a reasonable, cost-based fee for the costs of copying, mailing or other supplies associated with your request, up to \$0.75 per page for copied records. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access, you may request that the denial be reviewed by Citizens, Inc. and/or the New York State Office for Persons with Developmental Disabilities. Please contact our Privacy Officer if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Citizens, Inc. is not required to agree to a restriction that you may request, except we must agree to your request to restrict the information we provide to your health plan if the disclosure is not required by law and the information relates to health care being paid in full by someone other than the health plan. If Citizens, Inc. believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If Citizens, Inc. does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting our Privacy Officer in writing.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

**You may have the right to have Citizens, Inc. amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, pursuant to your request, or for notification purposes.

**You have the right to obtain a paper copy of this Notice from us,** upon request, even if you have agreed to accept this Notice electronically.

**Other Uses of Health Information:** Certain releases of health information may be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization.

### **3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by contacting the Office for Civil Rights, U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza - Suite 3312, New York, NY 10278; Phone (800) 368-1019. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Anne Miller, at (516) 293-111 x5477 or Judy Trent, Compliance Officer, for further information about the complaint process.

This Notice was published and becomes effective on 9/1/13.

**CITIZENS, INC.**  
**Acknowledgement of**  
**Receipt of**  
**Notice of Privacy Practices**

I, \_\_\_\_\_, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Individual or Individual's Representative

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Description of Representative's Authority,  
if Applicable

I make the following request for confidential communication or restriction on use or disclosure of my protected health information.