The Next Door Inc.
Treatment Services
965 Tucker Rd
Hood River, OR 97031
(541) 386-6665

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

CLIENT NAME: _____ ☐ **Adult** ☐ **Child**
DATE OF BIRTH:_____/_____/_____

I, _____authorize The Next Door Inc. Treatment Services (**NDI) to:**
Print Name
☐ **Release Information to:** ☐ **Obtain Information from:** ☐ **Exchange Information with:**

VIA: ☐ **Fax** ☐ **Mail** ☐ **Verbal**

NAME/ AGENCY	**ADDRESS**	**PHONE/FAX#**

HEALTH INFORMATION: The health information that is subject to this Authorization pertains to:
☐Myself ☐ My child_____ ☐ Other _____
Print Name Specify relationship

And includes the following:

☐ Mental health treatment (including assessments, progress notes, and other clinical records)
☐ Substance abuse treatment (including assessments and other clinical records, test results)
☐ Medication management
☐ To coordinate treatment and care with other agencies/professionals
☐ To assist in planning for services
☐ Case management services
☐ Information requested for legal purposes; Court-mandated
☐ Eligibility for services as a person with a developmental disability
☐ Appointment dates & times
☐ Demographic information
☐ Referral information
☐ HIV-related information: *I understand that this information may not be disclosed or re-disclosed without the specific written authorization of the individual to whom it pertains. [OAR §333-012-0270(9)(a)]*
☐ Other: _____

THE NEXT DOOR 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.

This notice is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA). Contact The Next Door, Inc. (NDI) in Hood River at phone# 541-386-6665.

This Notice describes the privacy practices of **The Next Door, Inc.** physicians, counselors, therapists, case managers, and other personnel. It applies to services furnished to you in Oregon, and Washington.

I. Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("**Protected Health Information**" or "**PHI**") and to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

II. Uses and Disclosures REQUIRING YOUR WRITTEN AUTHORIZATION

In certain situations, we must obtain your written consent or authorization ("**Your Authorization**") in order to use and/or disclose your PHI. You may cancel this authorization at any time in writing. NDI cannot take back any uses or disclosures already made with your prior authorization.

- **Uses and Disclosures of Your Highly Confidential Information.** Federal and Oregon law imposes special privacy protections for "Highly Confidential Information", which includes (1) treatment of mental illness, (2) alcohol and drug abuse treatment, (3) HIV/AIDS testing, (4) child abuse/neglect, (5) sexual assault, and (6) genetic testing. We must obtain your authorization in order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law.

- **Private Payors.** We must obtain your authorization to disclose PHI to your HMO, health insurer or other private payor.

III. Uses and Disclosures WITHOUT YOUR AUTHORIZATION

We may use and disclose your PHI without Your Authorization for the following purposes:

Treatment, Payment and Health Care Operations.

- Treatment. We use and disclose your PHI to provide treatment and other services to you. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.

- Payment. We may use and disclose your PHI to obtain payment for services that we provide to you from Medicare, the Oregon Medicaid program or another governmental program that arranges or pays the cost of some or all of your health care. We will obtain Your Authorization to disclose PHI to your private health insurer, HMO or other private payor. [179.505(4)(c)]
- Health Care Operations. We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you.

Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure. [164.510(b)]

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death. [164.510(b)]

Public Health Activities. We may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to the Oregon Department of Children and Family Services or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance. [164.512(b)]

Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to the Oregon Department of Human Services or other governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence. [164.512(c)]

Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid. [164.512(d).

Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. Further, unless specifically authorized by a court order, we may not use or disclose PHI identifying you as a recipient of alcohol and drug treatment services. [164.512(e)][42 CFR part 2]

Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. [164.512(f)].

Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law. [164.512(g)] [ORS 432.307(3)]

Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety. [164.512(j)]

Government Functions.

Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs. [164.512(l)] [OAR 436-010-0240(1)]

IV. Your Rights Regarding Your Protected Health Information

Complaints. If you are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with the Director or us.

Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Business Support Staff or your worker and submit the completed form to the Privacy Officer. We will send you a written response within 10 working days.

Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable **written** request for you to receive your PHI by alternative means of communication or at alternative locations. [164.522(b); 164.520(b)(1)(iv)(B)]

Right to Revoke Your Authorization. You may revoke Your Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Officer identified below. **[A form of Written Revocation is available upon request from the Business Support staff or your worker.]** [164.520(b)(1)(ii)(E)]

Right to Review and Receive A Copy of Your Record. You may request access to your medical record file and billing records maintained by us in order to review and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Business Support staff or your worker and submit the completed form to the Privacy Officer. If you request copies, we will charge you **$0.50** for each page. We will also charge you for our postage costs, if you request that we mail the copies to you.

Right to Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Office. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

As required by law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

V. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on April 14, 2003.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting rooms in our clinics. You also may obtain any new notice by contacting the Privacy Officer.

VII. Privacy Officer: You may contact the Privacy Officer at:

The Next Door, Inc.
Privacy Officer
965 Tucker Rd.
Hood River, OR 97031
541-386-6665

The Next Door Inc.
CONSENT TO TREATMENT, CONFIDENTIALITY and INFORMATION ON SERVICES

Services shall not be denied any person on the basis of race, color, creed, gender Sexual orientation, national origin, duration of residence, or financial circumstances.

1. *I am voluntarily seeking services from the Next Door Inc. Treatment Services (NDI) and both NDI and I have the right to terminate services at any time by simply notifying the other party of this intention.*

2. Services may include; assessments, individual and family counseling, individual and family therapy, parent training, personal skill development, progress evaluations, urinalysis, medication management, or referral to another agency.

3. I have the right and the responsibility to participate in the formulation of my treatment plan and no services shall be performed on my behalf unless I, or my guardian, have participated in its planning and have voluntarily agreed to it.

4. *Clients have the right to refuse treatment and have the right to an explanation of the consequences of such a refusal. Clients have the right for information regarding alternatives for care and treatment.*

5. I have the right to receive a full explanation of my assessment, treatment modalities, interventions, and review all notes, records, documents or other information regarding my diagnosis and treatment.

6. I have the right to receive a full explanation of my bills if required to pay.

7. I also understand that I have the right to freedom from abuse as defined by Oregon Revised Statutes 430.735 by any staff of The Next Door Inc. Treatment Services.

8. The following infractions may result in termination as well as possible legal action: Verbal or physical aggression toward other clients, staff or property of The Next Door Inc. Treatment Services; and/or Theft or vandalism of property of staff of The Next Door Inc. Treatment Services. Staff in this case may extend to foster parents and their property.

9. I understand that I may be audio or video recorded though I will need to sign a separate consent form to authorize audio or video recording.

10. **PATIENTS WHO ARE PRESCRIBED MEDICATION BY A PSYCHIATRISTS OR PHYSICIAN**

I understand that during the course of treatment, A Psychiatrist/Physician may prescribe medication and will explain the benefits of proposed treatment, the way treatment is to be administered, expected side effects or risks of side effects from medications, alternative treatment modes and probable consequences of not receiving proper treatment.

I understand that if I agree to take psychotropic medication prescribed by a physician I must see the doctor at least every 3months to review therapeutic dose that may include blood work.

I may review changes in medication that are kept in my filet. Should medication problems occur before medication check is scheduled; I should contact the physician, case manager, or therapist ***immediately.*** *Should the patient refuse recommended treatment, this is noted in the patient chart and other treatment potions explained to the patient.*

The following applies to clients participating in MENTAL HEALTH SERVICES:
I have received the Notice of Right to Make a Mental Health Advance Directive/ Declaration of Mental Health Treatment and understand that I may obtain more information on this matter from NDI staff, if I am interested.

The following CLIENT RESPONSIBILITIES applies to clients participating in ALCOHOL AND OTHER DRUG SERVICES:

a) Clients are to remain abstinent from alcohol and mood altering drugs. The treatment program may require urinalysis to substantiate this requirement. Attending individual or group sessions while intoxicated is grounds for termination.
b) Fees will be paid at time of service or on a weekly basis (unless otherwise arranged in written contract). Failure to comply may result in termination from program.
c) Clients are responsible for attending sessions as scheduled. Unexcused absences may be grounds for termination.

CONSENT TO PROGRAM SERVICES

I understand the above terms and information, and consent to participate in the services at The Next Door Inc. Treatment Services

Signed:_____ Date:_____
Client

Signed:_____ Date:_____
Parent/Guardian

8. I have received the Notice of Privacy Practices and understand that The Next Door Inc. Treatment Services staff will keep information about my case confidential, including the fact that I come to The Next Door Inc. Treatment Services for services, with the following exceptions:

a) My case may be discussed with staff members of *The Next Door Inc. Treatment Services* . The State Office of Mental Health and Addiction Services may audit my file for assurance of quality or treatment.
b) If a medical emergency occurs, information necessary to help me may be shared with my physician or other medical personnel.
c) In a life-threatening situation, information may be released to the appropriate authority.
d) *The Next Door Inc. Treatment Services* is legally obligated to report abuse of children, elderly, or disabled persons.
e) My case record and/or my counselor may be subpoenaed and information about me disclosed in a court of law.
f) Information (for example: age, sex, income, name, etc.) will be sent to the State Office of Mental Health and Addiction Services and will be used only for statistical purposes.
g) *The Next Door Inc. Treatment Services* may disclose information to other additional parties only when given written permission by me.
h) Any exceptions listed in the Notice of Privacy Practices provided to me.

9. I understand that I have the right to review my clinical records in the presence of a clinical staff OR have a copy of my records within 5 working days upon request and that I am responsible for the cost of

copying all or part of my records. I also understand that NDI does not re-disclose information not created by NDI staff.

10. I understand that if I have any unresolved complaints or concerns regarding my services, I have the right to use the complaint procedure that has been provided to me.

UNDERSTANDING OF CONFIDENTIALITY

I understand the above terms and information, and consent to participate in the services at The Next Door Inc. Treatment Services.

Signed:_____ Date:_____
Client

Signed:_____ Date:_____
Parent/Guardian

Client and/or guardian refused to:
☐ *receive or acknowledge receipt of the Notice of Privacy Practices*
☐ *sign consent because:*

_____ _____
Staff signature *Date*

For the purpose of:

☐ Coordinating treatment and care with other agencies/ professionals
☐ Assisting in planning for services
☐ Implementing case management services
☐ Determining eligibility for services as a person with a developmental disability

☐ I also consent for the release of *appointment related information only* (**via e-mail**, fax, or verbal) to the above-listed agency/agencies (e.g., school, juvenile department) and/or following member(s) of the Program Evaluation Team:
(Print Names)_____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until _____, 200___but not to exceed one year from today's date.
☐ Until the following event occurs:_____.
☐ Other:

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the quality of **NDI treatment of me, enrollment in the health plan, or eligibility for benefits.**

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to **NDI's Privacy Officer. The revocation will be effective immediately upon NDI 's receipt of my written notice, except that the revocation will not have any effect on any action taken by NDI in reliance on this Authorization before it received my written notice of revocation.**

I understand that once **NDI discloses my health information to any of the individuals/agencies specified above in accordance with the terms and conditions of this Authorization, NDI cannot guarantee that these individuals/agencies will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.**

If I have authorized NDI to disclose any information regarding ***drug and alcohol abuse/treatment***, I understand that Federal Rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally prosecute any alcohol or drug abuse patient." [42 CFR §2.32]

I understand that I may at any time make a written request to **NDI to inspect and/or obtain a copy of my health information, and that NDI will within FIVE (5) working days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.**

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize **NDI to use or disclose health information in the manner described above.**

_____ _____/_____/_____ _____
Signature of Individual Date Signature of Witness

☐ **Provided a copy of signed Authorization to individual**

If individual is 13 years or younger or is otherwise unable to sign this Authorization, please complete the information below:

_____ _____/_____/_____ _____
Signature Date Witness

Relationship to Client:

☐ Parent ☐ Guardian ☐ Authorized health care representative ☐ Health care power of attorney
☐ Other Authorized Personal Representative