

**WINSi**  
**WESTERN INSTITUTE FOR NEURODEVELOPMENTAL STUDIES**  
**AND INTERVENTIONS**  
**2501 Walnut Street, Suite 101**  
**Boulder, CO 80302**  
**Telephone: (303) 442-4750 Fax: (303) 443-4682**

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**I. Our Responsibility**

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

- Maintain the privacy of your health information as required by law;
- Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
- Follow the terms of our Notice currently in effect.

**II. Contact Information**

After reviewing this Notice if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person:

Privacy Officer  
2501 Walnut Street, Suite 101  
Boulder CO 80302  
303-442-4750

**III. Uses and Disclosures of Information**

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations.

**Treatment:** Your health information may be used by staff members or disclosed to other health care professions for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members. The doctors of WINSi may

consult with other professional colleagues or other professionals may be involved in your care to cover calls or the practice for the provider.

**Payment:** If we submit a bill to your health insurer to receive payment for your care, or if we are contacted by your health insurer to verify information regarding your assessment or treatment we will provide the insurer health information (for example, your diagnosis and what care we provided). In such situations, we will disclose only the minimum amount of information necessary to allow for payment or reimbursement.

**Health Care Operations:** We may use or disclose your health information to remind you about appointments or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you, such as case management or care coordination. Information may also be disclosed in the monitoring of service quality, staff evaluation and obtaining legal services.

#### IV. Other Uses and Disclosures

In addition to uses and disclosures related to treatment, payment, and health care operations, we may also use and disclose your personal information without authorization for the following additional purposes:

**Business Associates:** We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to service and maintain our computer systems, or to do our billing. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

**Minors:** If you are an unemancipated minor under Colorado law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

**Parents:** If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.

In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

**Family Members and Friends:** Protected health information cannot be provided to family members or friends without the client's consent. Exceptions to this rule include certain minors, incompetent clients or involuntary clients.

**Personal Representative:** If you are an adult or emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

**Public Safety:** Consistent with our legal and ethical obligations, we may disclose health information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement.

**Required By Law:** We may disclose health information about you as required by federal, state, or other applicable law. This may include, but is not limited to: 1) reporting child abuse or neglect; 2) when there is a legal duty to warn or take action due to an imminent danger to others; 3) when the client is a danger to self or others or is gravely disabled; 4) when a person may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition 5) when court ordered to release information; 6) when a coroner is investigating the client's death; or 7) for health care system oversight, government healthcare benefit programs or regulatory compliance

**Crimes on the Premises or Observed by the Provider:** Law enforcement will be notified of crimes that are observed by the provider or the provider's staff.

## **V. Your Health Information Rights**

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.
- Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.
- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.
- Request that we amend the health information about you that is maintained in our files and the files of our business associates (if applicable). Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.

- Request a list of our disclosures of your health information. This list, known as an “accounting” of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested (for example, “from May 1, 2003 to June 1, 2003”). We will be unable to provide you an accounting for any disclosures made before April 14, 2003 or for a period of longer than six years.
- Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section II above for information). If you have questions about your rights, please speak with our contact person, available in person or by phone.

#### **VI. To Request Information or File a Complaint**

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person (see section II above). You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-800-368-1019; or by sending an email to [OCRprivacy@hhs.gov](mailto:OCRprivacy@hhs.gov). We cannot, and will not, make you waive your right to file a complaint with HHS as a condition of receiving care from us, or penalize you for filing a complaint with HHS.

#### **VII. Revisions to this Notice**

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area(s) of our clinic and make copies available to our patients.

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**Patients' Acknowledgment of Receipt of Notice of Privacy Practices:**

**Patient Name:** \_\_\_\_\_

**Birth date:** \_\_\_\_\_

**Maiden or other name (if applicable):** \_\_\_\_\_

I acknowledge that I have received a copy of the Notice of Privacy Practices of the Western Institute for Neurodevelopmental Studies and Interventions.

**Signature** (Patient or authorized representative): \_\_\_\_\_

**Date:** \_\_\_\_\_

**Relationship/authority** (if signed by authorized representative): \_\_\_\_\_

