Against All Odds Integrated Community Care

Program Overview

Against All Odds Integrated Community Care is a licensed Outpatient Treatment Program. The agency is licensed to provide counseling, mentoring and other support services. Services have been requested for you and will be documented in your Treatment Plan.

In order to ensure, all parties involved are working toward each person meeting their individual treatment goals there are a few guidelines that must be followed. An overview of these items are provided below, this is not an all-inclusive list but rather a foundation of a successful program.

- Services will be scheduled based upon the treatment plan. This can be weekly or multiple times per week.
- It is important that scheduled meetings are completed on a consistent basis
- If there is any need to cancel, notify the AAO ICC representative that you're scheduled to meet with prior to the scheduled appointment.
- Multiple cancelations will be reported to Case Manager as well as a discussion regarding the continuation of services.
- Client participation is EXPECTED and REQIURED consistently in order to work toward meeting treatment and individual goal expectations.
- Programming is community based.
- Behavior must always be appropriate in-order to prevent your appointment from being impacted.
- Common courtesy and respect is EXPECTED and REQIURED.
- Wear seatbelts at all times while being transported. BE SAFE!
- Don't touch or take anything without out permission.
- Services provided will be documented and maintained in client file.

I wish to proceed with programming with Against All Odds Integrated Community Care

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

AAO ICC Staff Name	AAO ICC Staff Signature	Date

Against All Odds Integrated Community Care

Admission & Treatment Acknowledgement

Date:_____

To: _____ **RE: Client**_____

_____[Client] is agreeing to being receiving programming from Against All Odds Integrated Community Care (AAOICC) on:_____[date]. Client will be provided services defined in the client's treatment plan. We are looking forward to working with the client and providing care that will increase their chance of success in the community.

Against All Odds Integrated Community Care (AAO ICC) is an Outpatient Treatment program that strives to provide excellent care and services that include opportunities and activities geared toward assisting the client in successfully completing their treatment plan goals. Our mission states "Today's restoration is tomorrows celebration".

This letter is to rely the information that was provided to the client as part of the admission process. Information provided in this packet for your review includes:

_____ List of Emergency Numbers

_____ Copy of Grievance Policy

_____ Summary of Against All Odds Integrated Community Care Programming

_____ Privacy Notice

_____ Client Rights

_____Information Release

Please contact us with any questions or concerns. Please sign the acknowledgement of receiving these forms which are in the intake packet.

Regards,
Against All Odds Integrated Community Care

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

Against All Odds Integrated Community Care

Information Release Authorization

I authorize records to be release relevant to:

Client Name: _____

The client was admitted to our program on:_____

The release covers the following types of information related to the client's progress and status while at Against All Odds Integrated Community Care.
Please check all that apply:

	Behavioral Health		**Development**		**Social**		**Medical**
	Psychiatric		**Psychological**		**Photography**		**Audio**
	Identification		**Academic**		**Dental**		**Other:**

I further authorize Against All Odds Integrated Community Care to use the data obtained from these records as they deem necessary with the professional community. I fully understand the confidentiality of these records will be respected at all times and that these records will be made accessible only to those professional persons, or agencies that require such data in order to serve the client's best interest. A guardian can withdraw the consent anytime through written request, otherwise it expires 30 days after client is discharged from the program. The client may have a copy of this request.

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

AAO ICC Staff Name	AAO ICC Staff Signature	Date

Against All Odds Integrated Community Care

Transportation Release

This letter documents that with admittance into Against All Odds Integrated Community Care, you are consenting for the client to be transported to activities and service locations for purposes of treatment outlined in their treatment plan.

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

Against All Odds Integrated Community Care

Informed Consent

The information in this intake is provided to help you understand the treatment being recommended for you. Before we begin treatment, we want to be certain that we have provided you with enough information in a way you can understand, so that you're well informed and confident that you wish to proceed.

Against All Odds Integrated Community Care is an Outpatient Treatment program that strives to provide excellent care and services that include opportunities and activities geared toward assisting the client in successfully completing their treatment plan goals. Our mission states "Today's restoration is tomorrows celebration".

Acknowledgement,

I _____ , have received information about the proposed treatment. I have discussed treatment with Against All Odds Integrated Community Care personnel and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment. I understand that I will be provided services defined in the treatment plan.

I also acknowledge that I have received the following documents for my records and they were all reviewed at the time of intake:

_____ List of Emergency Numbers

_____Copy of Grievance Policy

_____Summary of Against All Odds Integrated Community Care Programming

_____ Privacy Notice

_____Client Rights

_____Information Release

By signing below, I acknowledged the I wish to proceed with the recommended treatment plan.

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

AAO ICC Staff Name	AAO ICC Staff Signature	Date

Against All Odds Integrated Community Care

Attendance Policy

Against All Odds Integrated Community Care is excited to serve you and your family. Attendance at regularly scheduled appointments is expected from every client. Parents / Guardians accept responsibility for regular attendance.

Clients are expected to arrive 5 minutes prior to their scheduled appointments. If a client is 15 or more minutes late, a therapist may not be able to see you for your scheduled appointment. If you are unable to attend your scheduled counseling appointment, please contact Against All Odds Integrated Community Care at least 24 hours in advance. If you fail to attend a scheduled appointment without notification or do not cancel at least 24 hours in advance, it is considered a missed session. If there is habitual absenteeism / missed sessions in a 12-month period, Against All Odds Integrated Community Care may close services for the client.

If services are closed, the client will need to work with their case manager to submit a new referral for counseling services.

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

Against All Odds Integrated Community Care

Confidentiality of Information

Most information discussed with your Against All Odds Integrated Care provider is confidential and protected by laws and will not be released without your written and only to the extent you authorize.

Information which may be disclosed even without your consent includes:

- When child abuse is known or suspected this is required by Arizona State Law.
- If a crime is committed.
- If you initiate a lawsuit against your provider.
- If you threaten to harm yourself or someone else.
- If you have a potentially life-threatening condition.
- If court orders disclosure of information.

Details of our services may be discussed with a clinical supervisor and/ or another Against All Odds Integrated Community Care provider (such as Against All Odds Integrated Community Care therapists, training facilitators or staff from another Against All Odds Integrated Community Care program[s]) for the purpose of consultation, team meetings and coordination of care.

Security of Records:

Our treatment records and related financial records are kept in a locked file cabinet in an office or other area not accessible to the public.

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

Against All Odds Integrated Community Care

Emergency Numbers

Agency	Address	Phone
911 Emergency		911
24-hour Crisis Hotline – National		1.800.273.TALK or 800.273.8255
AZ DES Adult Protective Services	4520 N. Central Ave Ste. 410 Phx, AZ 85012	888.767.2385
AZ Dept. of Health Services	150 N. 18th Ave Ste. 400 Phx, AZ 85007 Ste. 410 (4th Floor)	602.542.1025
AZ Dept. of Health Services - Medical Facility Licensing	150 N. 18th Ave Ste. 400 Phx, AZ 85007 Ste 450 (4th Floor)	602.364.3030
AZ Health Care Cost Containment System (AHCCCS)	801 E. Jefferson St. Phx, AZ 85034	602.417.4000
Chandler Fire Dept.	911 S. Hamilton St Chandler AZ 85224	480.782.2120
Chandler Police Dept.	250 E. Chicago St. Chandler AZ 85224	480.782.4130
Crisis / Suicide Hotline (by county)		
Gila River		800.259.3449
Maricopa County		602.222.9444
Pima County		800.796.6762 or 520.622.6000
Pinal, Yuma, LaPaz, Gila, Graham, Cochise, Greenlee, Santa Cruz		866.495.6735
Yavapai, Navajo, Mohave, Apache Coconino		877.756.4090
Dept. of Child Safety	4635 S. Central DCS Building Phx, AZ 85040	602.276.5772
Gila River Fire Dept.	5002. N. Maircopa Rd Chandler AZ 85226	520.795.5900
Gila River Behavioral Health Clinic	P.O. Box 38 Sacaton, AZ 85147	602.528.7140 or 520.562.7140
Gila River Hospital	483 Seed Farm Rd. Sacaton, AZ 85147	520.526.3321
Gila River Police Dept.	P.O. Box 2186 Sacaton AZ 85247	520.562.7106
Gila River RBHA	P.O. Box 38 Sacaton, AZ 85147	602.528.7140 or 520.562.7140
Gila River RBHA Help Line	150 N. 18th Ave Ste. 410 Phx, AZ 85007 (4th Floor)	800.4259.3449
Gila River Tribal Social Services	P.O. Box 38 Sacaton, AZ 85147	520.562.3396 or 480.899.9565
Gilbert Fire Dept.	85 E. Civic Center Dr. Gilbert, AZ 85296	480.503.6300
Gilbert Police Dept.	75 E. Civic Center Dr. Gilbert, AZ 85296	480.503.6300
Guadalupe Fire Dept.	8413 S. Avenida Del Yaqui Guadalupe, AZ 85283	480.839.1112
Guadalupe Police Dept.	8201 S. Hardy Dr. Tempe, AZ 85234	480.350.8311
Human Rights Advocate	150 N. 18th Ave Ste 210 Phx, AZ 85007 (2nd Floor)	602.3634558
Mercy Care Member Services	4350 E. Cotton Center Blvd Phx, AZ 85040	800.624.3879 / 602.263.3000
Mesa Fire Dept.	830 Stapley Dr. Mesa, AZ 85204	480.644.2101
Mesa Police Dept.	130 N. Robson Mesa, AZ 85201	480.644.2211
Pascua Yaqui 24 hr. Crisis Line		Tucson: 520.591.7206 Guadalupe: 480.736.4943
Pascua Yaqui	7474 S. Camino De Oeste Tucson, AZ 85746	520.883.5060
Pascua Yaqui	7474 S. Camino De Oeste Tucson, AZ 85746	520.883.5060
Pascua Yaqui	9405 S. Avenida Del Yaqui Guadalupe, AZ 85283	480.768.2000
Phoenix Fire Dept.	1601 N. 3rd Ave Phx, AZ 85003	602.262.6910
Phoenix Police Dept.	1902 S. 16th St. Phoenix AZ 85034	602.495.5005
Poison Control		800.362.0101 or 602.253.3334
Queen Creek Fire	22358 S. Ellsworth Rd. Queen Creek, AZ 85142	480.358.3360
Queen Creek Police	20727 E. Civic Parkway Queen Creek, AZ 85142	602.876.1011
Tempe Fire Dept.	1450 E. Apache Blvd, Tempe AZ 85281	480.858.7200
Tempe Fire Dept.	1450 E. Apache Blvd, Tempe AZ 85281	480.858.7200
Tempe Police Dept.	120 E. 5th Tempe, AZ 85281	480.350.8311

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

Today's restoration is tomorrows celebration!

Against All Odds Integrated Community Care

Grievance Policy

Against All Odds Integrated Community Care has established a grievance procedure client's and their guardians to grieve alleged violations. Clients are allowed to file a grievance without violation of, or threat of violation of their rights or privileges. If there are concerns related to interactions with Against All Odds Integrated Community Care staff, the equality of care provided by staff or the belief that there has been a possible client's right violation, the following process is available to address the concern(s).

1. Client are to bring concerns or complaints directly to any Against All Odds Integrated Community Care clinical staff.

2. If the discussion does not resolve the issue or you are unsatisfied with the outcome, she/he may write a letter of complaint to Against All Odds Integrated Community Care -------- Attention: Administrator and explain his / her concerns.

- Within three (3) working days of receipt of the written grievance, a supervisor or designee will meet with the client, child and/ or parent/ guardian.
- Staff or designee will issue a written response within five (5) working days of the meeting.

After following the above procedure, or any time before or during this procedure the child and/ or guardian/ parent has the right, to contact the Arizona Department of Health Services Behavioral Health Licensure by calling 602.542.0883 or writing to 150 N. 18th Ave Phoenix, Arizona 85007.

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

AAO ICC Staff Name	AAO ICC Staff Signature	Date

Against All Odds Integrated Community Care

Client Rights

Posting and Documentation of Client Rights:

a) Against All Odds Integrated Community Care (AAOICC) will post a list of client rights in a conspicuous area accessible to all clients pursuant to A.R.S § 36-504(A) in both English & Spanish.
b) AAOICC shall document the client's receipt of his / her client's rights in the client file. The client rights will be reviewed verbally by AAOICC staff, and a copy of the client rights will be given to the client upon intake. The client will sign off on the Client Rights acknowledging their understanding of the Client Rights and Responsibilities.
c) A client's parent, guardian, custodian or agent (if applicable) acknowledges. In writing receipt of the written list and verbal explanation of the Client Rights upon intake.
d) A client who does not speak English or who has a physical or other disability will be assisted in becoming aware of client rights.

A client has the following rights:

1. To be treated with dignity, respect and consideration.
2. Not to be discriminated against based upon race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis or source of payment.
3. To receive treatment that:

a. Supports and respects the client's individuality, choices, strengths and abilities;
b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order, by the client's general consent or as permitted in this chapter and
c. Is provided in the least restrictive environment that meets the client's treatment needs

4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category or rights.
5. To submit a grievance to agency staff members and complaints to outside entities and other individuals without constraint or retaliation.
6. To have grievances considered by a license in a fair, timely and impartial manner.
7. To seek, speak to and be assisted by legal counsel of the client's choice at the client's expense.
8. To receive assistance from a family member, designated representative or other individual in understanding, protecting or exercising the client's rights.
9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting or exercising the client's rights.
10. To have the client's information and records kept confidential and released only as permitted under R9-10-211(A)(3) and (B).
11. To privacy in treatment including the right o to be fingerprinted, photographed or recorded without general consent, except:
    a. For photographing for identification and administrative purposes as provided by A.R.S. §36-507(2).
    b. For a client receiving treatment per A.R.S. Title 36, Chapter 37

c. For video recordings used for security purposes that are maintained only on a temporary basis or
d. As provided in R9-10-602(A)(5);

12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-10-211(A)(6).
13. To review the following at the agency or at the Department:
    a. This Chapter,
    b. The report of the most recent inspection of the premises conducted by the Department.
    c. A plan of correction in effect as required by the Department.

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

AAO ICC Staff Name	AAO ICC Staff Signature	Date

Against All Odds Integrated Community Care

Media Release

From time to time during Against All Odds Integrated Community Care activities, outings or events including the Against All Odds Integrated Community Care excursions, participants may be photographed, videotaped or interviewed. These will be for the enjoyment of the participants, and also may be used in promotions to generate interest. Images of and statements by your child may be used.

Since it is difficult to gather permission after the fact, all participants must have a signed release on file. Thank you for your cooperation in this matter.

_____ I, the undersigned, do hereby grant to Against All Odds Integrated Community Care the right to use my child's name and likeness, program/ personal success, photographs and interviews of him/ her in his/ her with Against All Odds Integrated Community Care in all media.

_____ I, the undersigned, understand that the release and consent given herein, is made without compensation and no compensation is required or anticipated. I hereby release Against All Odds Integrated Community Care from any and all liability, claims, or causes of action with this consent and release.

_____ I consent media release guidelines

_____ I decline media release guidelines

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

Against All Odds Integrated Community Care

Private Health Information Policy

1. You have the right to confidential communications and to ask us to communicate with you about health-related issues in a way or place that is more private for you. We will work to accommodate reasonable requests.
2. You have the right to ask us to limit our disclosures to people involved in your care whether for payment. Family or other individuals. We are not required to agree to your request. However, if we do agree, we will maintain our agreement except hen against the law, in an emergency or when the information is necessary to treat you. We require the request for restriction to be submitted in writing to Against All Odds Integrated Community Care.
3. You have the right to examine your information, such as medical or billing records (excluding psychotherapy / progress notes). You may be able to receive a copy of these records upon request to our agency and by a paying a fee.
4. You have the right to ask to amend (note errors) or add information to your record. However, you must submit a written request to our Privacy Officer for review and we can only amend or add information to your record that was generated by our agency.
5. You have the right to a copy of this notice. If we amend this notice, we will give you a copy.
6. You have the right to file a privacy complaint if you feel your privacy rights have been violated and can file a complaint with our Privacy Officer or the Department of Health and Human Services.
7. You have a right to a paper copy of this notice at any time and can request a copy from Against All Odds Integrated Community Care at any time.

Change to this notice:

We reserve the right to change this notice. We reserve the right to make the revised notice effective for the medical information we already have about you as well as any information we receive in the future.

Complaints:

You may contact Against All Odds Integrated Community Care or the Arizona Department of Health and Human Services if you believe your privacy rights have been violated.

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

Effective Date: Jan 9th, 2019

Against All Odds Integrated Community Care

Privacy Notice

This document describes the type of information we gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your health information and the right to approve or refuse the release of specific information except when the release is required by law. If the practice described meets your expectations. There is nothing you need to do. If you prefer that we not share information we may honor your written request in certain circumstances described below. If you have any questions about this notice, please contact us at the information below.

Who will follow this notice?

This notice describes Against All Odds Integrated Community Care practice regarding the use of your health information and that of:

- Any health care professional authorized to enter information into your chart or medical records
- All employees, staff and other personnel who may need access to your information

Our pledge regarding health information:

We understand that health information about you and your health is personal. Protecting health information about you is important. We create a record of care and services you receive. 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 Against All Odds Integrated Community Care professional or other personnel.

This notice will tell you about the ways in which we my use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

- Keep health information that identifies you, private
- Give you this notice of our legal duties and privacy practices with respect to health information about you and;
- Follow the terms of the notice that is currently in effect.

How may we use and disclose health information about you?

For Treatment:

We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, training doctors or other health care professional who are involved in taking care of you. Different health care professional also may share health information about you in order to coordinate the different things you need, such as prescriptions and lab work. We also may disclose health information about you to people outside the

agency who may be involved in your medical care after you leave or that provide services that are part of your care.

For Payment:

We may use and disclose health information about you for billing you, any payor, administrative agency or organization who is the payor of any part of or all of your treatment services so that we may receive payment for treatment we have provided. We may need to be in contact with your payor to find out what services they cover, inform them of your diagnoses, report on the treatments or services you have received and discuss the changes we anticipate in your conditions. Additionally, we will need to discuss with your payor other matters such as when we meet and our progress and / or lack thereof as well as treatment recommendations or discontinuation of services.

Individuals Involved in Your Care or Payment of Your Care:

We may release health information about you to a family member or friend who is involved in your medical care and for whom have provided us with a signed Release of Information and will limited what is shared based on what you have permitted as noted on this signed Release of Information, this must be submitted in writing. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status or location.

For Health Care Purposes:

We may use and disclose health information about you for health are purposes. This is necessary to make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate he performances of our staff in caring for you. We may also disclose information to doctors, nurses, technicians and other personnel for review and learning purposes. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific patients are.

For Health Care Operations:

We may use your health information for health care operations including but not limited to the evaluation of the quality of health care services offered to you or for other evaluative needs, for obtaining or marinating any licensure certification accreditation, for responding to audits for outcomes measures or as requested by other agencies, courts, departments, whom have referred you here, that we have contracts with.

For Health Information:

Anytime you visit a healthcare provider, either for medical or mental health care, information about you and your health is collected. The information collected can be related to your past, present or future health related to test(s), treatment you received from us or others, or related to payment for healthcare services. The information that is collect from you is, by law, called Protected Healthcare Information and is part of your medical or health care record.

At this office Protected Health Information is likely to include information about the following:

- Your personal history
- Reasons for treatment
- Diagnoses (a term indicating problem / symptoms defined by the Diagnostic and Statistical Manual.

- A treatment plan. Which identifies your goal (s) for treatment and ways we can work with you to support you in meeting these goals
- Progress Notes or "case management" notes, which are a record of our interaction each time we meet or have contact.
- Records from other healthcare providers you have been to see
- Psychological test scores, school records, additional evaluations or reports.
- Medical information including medications you have been prescreened and / or are taking
- Legal matters
- Billing and insurance information

***** the above list is to provide you an understanding of what might be in your record; However, there might be other information included in your record. *****

We may use your Protected Health Information for multiple purposes, which may include the following:

- For planning and implementing care and treatment.
- To assess the effectiveness of treatment
- For talking with other healthcare professionals such as other treatment providers or for other professionals that referred you to treatment.
- For documentation that you received the services from us we indicated in billing purposes of you or your payor.
- For teaching or training other staff or mental health professionals
- For research
- For public health officials who are striving toward improving healthcare in this part of the country.
- To be able to measure the results of our work so as to improve the way we provide treatment and services,

Signed Release of Authorization:

We may use and disclose health information about you to those involved in your care and whom have provided us with a signed Release of Information and will limited what is shared based on what you have permitted as noted on this signed Release of Information, this must be submitted in writing.

Appointment Reminders:

We may use and disclose health information to contact you as a reminder that you have an appointment for treatment.

Treatment Alternatives:

We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services:

We may use and disclose health information to tell you about health related benefits or services that may be interest to you.

As Require by Law:

We may use and disclose health information about you when required to do so by federal, state or local law.

To Avert Serious Threat to Health or Safety:

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health or safety of the public or another person.

Fund Raising Activities:

We may use and disclose health information about you in an effort to raise money for Against All Odds Integrated Community Care and it operations. We may use and disclose health information to a foundation related to the agency so that the foundation may raise money for the agency. We only would release contact information, such as your name, address and phone number. If you do not want Against All Odds Integrated to contact you for fund-raising efforts, you must notify Treatment Coordinator in writing at the address below.

Special Situations:

Organ and Tissue Donation:

If you are an organ door, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans:

If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Workers' Compensation:

We may release information about you for workers' compensation or similar programs these programs provide benefits for work-related injuries or illness.

Public Health Risk:

We may disclose health information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report relations to medications or problems will products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse or domestic violence.

Health Oversight Activities:

We may disclose health information to a health oversight agency for activities authorized by the 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 right laws.

Lawsuits and Disputes:

We may disclose health information about you in response to subpoena, discovery request or other lawful order from a court.

Law Enforcement:

We may release information if asked to do so by law enforcement official as part of law enforcement activities; investigations of criminal conduct or of victims of crime in response to court orders, in emergency circumstances or when required to do so by law.

Coroners, Medical Examiners and Funeral Directors:

We may release information if asked 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 health information about patients of the agency to funeral directors as necessary to carry out their duties.

Protective Services for the President, National Security and Intelligence Agencies and Activities:

We may release information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counter intelligence and other national security activities authorized by law.

Inmates:

If you are an inmate of correctional institution or under the custody of a law enforcement official, we may release health information about you 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.

Your rights regarding health information about you:

Right to Inspect and Copy:

You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical billing records, but does not include psychotherapy notes.

To inspect and copy health information that may be used to make decisions about you. You must submit your request in writing to our Treatment Coordinator. 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 very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by Against All Odds Integrated Community Care will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend:

If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept.

To request an amendment, your request must be made in writing and submitted to our Treatment Coordinator. In additional you must provide a reason that supports your 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 information that:

- Was not created by us, unless the person or entity that created the information if no longer available to make the amendment.
- Is not part of the health information kept by Against All Odds Integrated Community Care.
- Is not part of the information which you would be permitted to inspect and copy
- Is accurate and complete.

Right to Accounting of Disclosures:

You have the right to request an "account of disclosures" this is a list of the disclosures we made of health information about you.

To request this list or an accounting of disclosures, you must submit your request in writing to our Treatment Coordinator. Your request must state a time period that may not be longer than six (6) years and may not include dates before January 15th, 2019. Your request should indicate in what form you want the list (i.e. on paper or electronically). The first list you request within a 12-month period be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost incurred.

Right to Request Restrictions:

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. Like a family member or friend.

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

To request restrictions, you must make a request in writing to our Treatment Coordinator. 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; (3) to whom you want the limits to apply.

Right to Paper Copy of this Notice:

You have the right to a paper copy of this notice any time. Even if you have agreed to this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of the current notice, please request one in writing to our Treatment Coordinator.

Right to Request Confidential Communications:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by email.

To request confidential communications, you must make your request in writing to our Treatment Coordinator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Change to This Notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed notices effective for healthcare 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. The notice will contain on the first page, in the top right-hand corner the effective date.

Complaints:

You may file a complaint with Against All Odd Integrated Community Care or directly with the Department of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with Against All Odd Integrated Community Care by submitting your complaint in writing to our Treatment Coordinator. Against All Odd Integrated Community Care will not intimidate, threaten, coerce, discriminate against or take other retaliatory action(s) against any individual for filing a complaint, for testifying, assisting, participating in any manner in an investigation, any, any compliance review, proceeding or hearing.

Other Uses of Health Information:

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission, in writing at any time. If you revoke your permission, thereafter, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I have read and received a copy of this Privacy Notice.

Client Name	Client Signature	Date

Parent / Guardian Name	Parent / Guardian Signature	Date

AAO ICC Staff Name	AAO ICC Staff Signature	Date