Marion County
OREGON
Health & Human Services

Marion County Wraparound

RE: Information & Referral Packet for Marion County Wraparound

Thank you for your interest in the Wraparound Program. We have enclosed some important information for you to review along with your intake referral packet to complete. Please return the referral packet along with a copy of a recent mental health assessment that has been completed **within the last year.** Your mental health provider can assist you with this.

Please mail or drop off your completed referral packet (please note forms in color need to be returned in color) and a mental health assessment to:

Marion County Wraparound
3876 Beverly Ave NE, Bldg G, Salem, OR 97305
Fax: 503-361-2782 **OR**
Email: WRAPOS@co.marion.or.us

Once we have received the completed referral packet, and a mental health assessment, one of our Qualified Mental Health Professionals will be contacting you to begin our eligibility process to determine if the Wraparound program matches the of your youth/family, or if other services and supports would be more appropriate.

Please let us know if you have any questions or if we can be of any assistance. I can be reached by phone at 503-576-4536. Thank you for your time and attention to this process. We look forward to working with you in support of your child.

Please return the following items:

- Completed Referral Packet
- Current Mental Health Assessment completed in the last year.
- OHP ID #_____

WRAPOS@co.marion.or.us

Incomplete packets will not be processed

Marion County
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Health & Human Services

Marion County Health Department
YOUTH & FAMILY INFORMATION

Select Program: ☐ **WrapAround** ☐ **JWRAP** ☐ **Rapid Access Assessment**

Individual's Name: _____ Today's Date: _____

DOB: ____/____/____ SS#: _____ Race/Ethnicity: _____

OHP# _____
For JWRAP: Commercial Ins Provider: _____ Ins#: _____ ☐ No Insurance

Legal Sex: F◯ M◯ Identified Gender: _____

School Name: _____ Grade: _____ IEP/504 Plan: Yes◯ No◯

Parent Guardian Name: _____

Biological Mother: _____ Biological Father: _____

Address: _____

Best Contact #: (____) ____-_____ Is this: Home#◯ Cell#◯ Work#◯

OK to leave message? Yes◯ No◯ Email: _____

Interpreter needed? Yes◯ No◯ Language: _____

CURRENT SERVICE PROVIDERS—Please list name and phone number of contact person

Agency/Provider	Name	Contact Information
Mental Health:		
Primary Care Physician:		
Medical Issues:		
Current Medications:		
Prescriber's Name:		
Juvenile Probation/OYA:		
Assigned Back-Up:		
Juvenile Counselor:		
DHS Case Worker:		
Resource Parent:		
Alcohol/Drug Provider:		
Residential Provider:		
Other:		

CURRENT HOUSEHOLD MEMBERS

Name	Relationship	Age or Date of Birth	Grade/Occupation

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Consent For Treatment

I have read and/or had the following explained to me as part of my orientation to services with Marion County Health & Human Services (initial those that apply):

____ Rights and Responsibilities

____ Complaint and Grievance Procedure

____ Welcome Letter

If 18 years or older, initial those that apply

____ I was asked if I have completed an Advanced Directive

____ I was offered a Voter Registration Card

Declaration for Mental Health Treatment

Does the client have a Declaration for Mental Health form completed? Yes☐ No☐

If no, was the client offered the opportunity to complete a Declaration for Mental Health Treatment? Yes☐ No☐

I understand the risk and benefits as explained to me. I give Marion County Health and Human Services permission to provide me with evaluation and treatment services.

_____ _____

Signature (Individual or Guardian) Date

_____

Individual's Printed Name

☐ Refused to Sign	☐ Not Able to Sign
Circumstances for refusal/inability to sign:	

Revised 10/22

Marion County
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Marion County Health & Human Services

NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

PLEASE REVIEW THIS ACKNOWLEDGEMENT CAREFULLY AND THEN SIGN AND DATE BELOW.

The Notice of Privacy Practices tells you how the Marion County Health Department may collect, use or disclose health information about you and tells you about your privacy rights. The Health Department is required to offer you a Notice of Privacy Practices by federal law.

I, _____

Client's Printed name

have been offered a copy of the Marion County Health Department's Notice of Privacy Practices and have had a chance to ask questions about how my health information will be collected, used and disclosed and how to access my privacy rights.

_____ _____

Client's Signature **Date**

_____ _____

Legal or Personal Representative of Client (if applicable) **Relationship**

This document is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA).
Contact your Service Provider, or call the general number for the Health Department at: Phone# 503-588-5357, or Fax# 503-364-6552.

Health Department Staff: *Please have this document completed and signed by the individual receiving the Notice of Privacy Practices.*

Marion County
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Marion County Health & Human Services

FEE AGREEMENT

I understand that any fees assessed for services that I receive at Marion County New Solutions will be based on my income, the number of dependents in my family and on the Income Guidelines printed on the back of this form. My established payment for services, if any, will be based on the New Solutions charges also listed on the back of this form.

I understand that if I have private insurance coverage, other than Medicaid/OHP, Marion County New Solutions will bill my insurance company first and I may be held responsible for any co-pays or amounts not covered by my insurance. I understand that this fee agreement will apply to those amounts not covered by my private insurance.

If my situation warrants the establishment of fees, I understand and agree to make payment directly to Marion County New Solutions. I agree to be responsible to report any changes in my situation that may impact my fee agreement to the New Solutions staff in a timely manner.

I understand that if I do not follow this agreement, the New Solutions Program reserves the right to deny future service.

FEE REDUCED OR WAIVED

☐ Fee Reduction to _____% of the full fee for service charge

☐ Fee Waiver

Comments: _____

_____

Supervisor Signature: _____ Date: _____

VOID

I understand and agree to the conditions listed above regarding the fee reduction or waiver.

Signature: _____ Date: _____
Parent/Legal Guardian

MEDICAID/OHP COVERAGE

☐ Bill Medicaid/OHP Client Name: _____

I understand that I will not be charged any fees as long as I have Medicaid/OHP coverage nor be responsible for any charges not Medicaid/OHP.
I understand that if my Medicaid/OHP coverage is terminated, a new Fee Agreement will be completed to reassess my ability to pay and will be retroactive to the Medicaid/OHP termination date.
I agree to be responsible to report and changes in my Medicaid/OHP coverage to the New Solutions staff in a timely manner.

Parent/Legal Guardian Signature: _____ Date: _____

Revised 9/2021

Marion County
OREGON
Health & Human Services

Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN	#		
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): Health Care Provider/PCP:	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible):	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type***.) **HIV/AIDS: _____** **Mental health: _____** **Genetic testing: _____** **Alcohol/drug diagnoses, treatment, referral: _____**	
RELEASE TO	
Release to (entity name): Marion County Health & Human Services	
Contact person:	Phone number: 503-576-4536
Address, City, State, and ZIP: 3876 Beverly Ave NE, Building G, Salem, OR 97305	
Email address:	Fax number: 503-361-2782
Purpose of the requested use or disclosure: Continuity of Care	
Are these records being released for a court case? ◯ Yes ◯ No	
Expiration date or event*: 1 Year	Mutual Exchange: ◉ Yes ◯ No

**This authorization is valid for one year from the date of signing unless otherwise specified.*

YOUR ACKNOWLEDGMENT
• I was given the opportunity to ask questions about this form and what it does. • I understand that state and federal law protect information about services I receive from Marion County Health & Human Services. I understand what this agreement means and I approve of the disclosures or releases listed. • I understand that I can revoke (*cancel*) this authorization at any time, and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, the individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request in writing. Oral or written notification of the revocation of authorization for drug and alcohol information shall be accepted. Any request for revocation must be provided to your local Marion County program. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without specific authorization. • I understand that the information not subject to limitations on re-disclosure, as noted immediately above, may be subject to re-disclosure and no longer protected under federal or state law. • **I am signing this authorization of my own free will.**
Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

To provide or pay for health services: If Marion County is acting as a **provider** of your health care services, or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be: assessments, tests, or evaluations*.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS, OHA or Marion County Health service, where MCHHS is not acting as a health care provider

This is a voluntary form. Marion County cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs upon signing this authorization, except as described above. However, you should be given accurate information about how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Marion County
OREGON
Health & Human Services

Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN	#		
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): Health Care Provider/PCP:	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible):	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type***.) **HIV/AIDS: _____** **Mental health: _____** **Genetic testing: _____** **Alcohol/drug diagnoses, treatment, referral: _____**	
RELEASE TO	
Release to (entity name): Marion County Health & Human Services	
Contact person:	Phone number: 503-576-4536
Address, City, State, and ZIP: 3876 Beverly Ave NE, Building G, Salem, OR 97305	
Email address:	Fax number: 503-361-2782
Purpose of the requested use or disclosure: Continuity of Care	
Are these records being released for a court case? ◯ Yes ◯ No	
Expiration date or event*: 1 Year	Mutual Exchange: ◯ Yes ◯ No

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Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

To provide or pay for health services: If Marion County is acting as a **provider** of your health care services, or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be: assessments, tests, or evaluations*.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

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Marion County
OREGON
Health & Human Services

Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN	#		
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): Health Care Provider/PCP:	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible):	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type***.) **HIV/AIDS: _____** **Mental health: _____** **Genetic testing: _____** **Alcohol/drug diagnoses, treatment, referral: _____**	
RELEASE TO	
Release to (entity name): Marion County Health & Human Services	
Contact person:	Phone number: 503-576-4536
Address, City, State, and ZIP: 3876 Beverly Ave NE, Building G, Salem, OR 97305	
Email address:	Fax number: 503-361-2782
Purpose of the requested use or disclosure: Continuity of Care	
Are these records being released for a court case? ◯ Yes ◯ No	
Expiration date or event*: 1 Year	Mutual Exchange: ◯ Yes ◯ No

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Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

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FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

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Marion County
OREGON
Health & Human Services

Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	First name:	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN	#		
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name): Texting	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible):	

Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type.***)

HIV/AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Alcohol/drug diagnoses, treatment, referral: _____

RELEASE TO	
Release to (entity name):	
Contact person: Marion County Health & Human Services	Phone number: 503-576-4536
Address, City, State, and ZIP: 3876 Beverly Ave NE Bldg G Salem OR 97305	
Email address:	Fax number: 503-361-2782
Purpose of the requested use or disclosure: Continuity of Care	
Are these records being released for a court case? ◯ Yes ◯ No	
Expiration date or event*: 1 Year	Mutual Exchange: ◉ Yes ◯ No

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Signature of individual or legal representative:

Printed name:	Date:

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Signature of agency staff certifying true copy:		
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Required information for the client

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Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	First name:	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN	#		
Legal last name of representative:	First name:		MI:

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RELEASE FROM	
Release from (entity name): Email	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible):	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information type.***) **HIV/AIDS:** _____ **Mental health:** _____ **Genetic testing:** _____ **Alcohol/drug diagnoses, treatment, referral:** _____	
RELEASE TO	
Release to (entity name):	
Contact person: Marion County Health & Human Services	Phone number: 503-576-4536
Address, City, State, and ZIP: 3876 Beverly Ave NE Bldg G Salem OR 97305	
Email address:	Fax number: 503-361-2782
Purpose of the requested use or disclosure: Continuity of Care	
Are these records being released for a court case? ◯ Yes ◯ No	
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Signature of individual or legal representative:
Printed name: / Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.

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FOR AGENCY USE ONLY		
Name of staff (print):	Initiating agency name/location:	Date:
Signature of agency staff certifying true copy:		
Initial and date (if form has been copied):		

Required information for the client

To provide or pay for health services: If Marion County is acting as a **provider** of your health care services, or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be: assessments, tests, or evaluations.)* Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

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Marion County
OREGON

INDIVIDUAL RIGHTS AND RESPONSIBILITIES

As an individual served by Marion County Health Department, we want to assure that your rights and responsibilities will be respected. The following is a summary of your rights and responsibilities. Please feel free to ask any questions you may have concerning this information.

YOUR BASIC RIGHTS

1. You can access and receive services regardless of race, color, religion, sex, sexual orientation, age marital status, national origin and mental or physical disability.
2. You will receive courteous and timely service in an environment that offers reasonable safety, protection from harm, and reasonable privacy.
3. You have the right to be free from seclusion, restraint, abuse and neglect.
4. You may report any incident of abuse or neglect without being subject to retaliation.
5. You will be treated with dignity and respect.
6. You will not involuntarily participate in experimentation.

YOUR ACCESS AND INFORMATION RIGHTS

7. You can access and receive services in a manner and language consistent with your culture, including access to an interpreter if needed.
8. You will be asked to give informed consent in writing prior to the start of services.
9. You will receive information about the policies and procedures, service agreements and fees applicable to the services provided.
10. You will receive information about other community resources and other available treatment.
11. You may receive services and treatment without custodial parent or legal guardian consent when lawfully married, 16 or older and legally emancipated by the court, or age 14 or older for outpatient services only.
12. You have the right to receive emergent care 24 hours per day, 7 days per week and to be informed how and where to receive the care.

YOUR TREATMENT RIGHTS

13. You will receive quality care and services.
14. You may request information concerning the credentials and training of staff.
15. You can participate in the development of a written services plan, receive services consistent with that plan and participate in periodic review.
16. You may receive a copy of the written ISSP.
17. Your family and others of your choice may participate in this planning and review.
18. You have the right to ask about risks and benefits of treatment and about alternate treatment methods.
19. You will receive medication specific to your diagnosed clinical needs.
20. You will be informed about the side effects of any medications.
21. You can choose from available services and supports those that are the least restrictive, least intrusive, and that provide for the greatest degree of independence.
22. You can access the materials in their Individual Service Record, clinical and/or medical record which were originated by the Health Department.
23. Upon written request, you will receive copies of your clinical or medical records which were originated by the Health Department.
24. Consistent with state and federal laws, information about you and your treatment will be kept confidential.
25. You must give written permission before information concerning your treatment or services can be shared.

26. Your confidential information can be released without consent only when:
    a. A court orders release of information under certain limited circumstances
    b. There is a clear danger to the you or others
    c. There is reasonable cause to believe that neglect or abuse of a child, elder, person with developmental disabilities or nursing home patient has been or is occurring
    d. Under limited circumstances if the individual is a minor (dependent on the type of treatment being delivered.)
    e. To obtain reimbursement from your insurance.
    f. To coordinate your care with the Mid-Valley Behavioral Care Network/Oregon Health Plan (if you have that coverage).
27. You can choose to refuse treatment including any specific procedure or medication.
28. You have the right to execute a Declaration of Mental Health Treatment and to receive help with completing the Declaration.
29. You have the right to receive information about medical Advanced Directives.
30. You will receive prior notice of service conclusion or transfer, if services will be reduced or terminated.

YOUR OTHER RIGHTS

31. OHP/MVBCN members have additional rights and responsibilities. These additional rights and responsibilities will be distributed to OHP/MVBCN members at intake and be made available in the reception areas. These can also be found on the MVBCN website, www.mvbcn.org.
32. You can file a written or oral grievance or complaint relating to treatment or providers and receive assistance in filing the complaint.
33. You will not be punished or retaliated against if you file a complaint.
34. You will not be punished for exercising your rights.

YOUR RESPONSIBILITIES

35. You will treat others with courtesy and respect.
36. You will provide information that is needed in order to provide care.
37. You will participate, in the degree possible, in developing mutually-agreed upon treatment goals.
38. You will follow the treatment plans you have agreed to.
39. You will inform care givers/practitioners of any dissatisfaction with services or treatment.
40. You will arrive on time for scheduled appointment or call in advance if an appointment must be cancelled or rescheduled.
41. You will inform care givers/practitioners of changes in address, telephone numbers, and other personal information relating to their treatment.
42. You will bring insurance information and cards to appoints and inform care givers/practitioners of any changes in coverage.
43. You will take medications as prescribed or consult the prescriber before making any medication changes.
44. You will seek help for any addiction or mental health issues that may interfere with treatment.
45. You will protect the confidentiality and safety of other individuals.
46. You will pay for any services detailed in a fee agreement.

Marion County
OREGON

COMPLAINTS AND GRIEVANCE PROCESS

What should you do if you feel your rights have been violated or if you disagree with or are unhappy with services?

We ask that you talk about the problem and your situation with your counselor or prescriber. If you do not find resolution for the situation, you may discuss it with a supervisor.

OR

If you want to file a complaint, you or a person you choose to act in your behalf, can submit a verbal or written complaint/grievance.

How do you file a complaint?

Complaint forms can be found in the lobby area or they can be downloaded from the Health Department website. You can also file a verbal complaint with your case manager or any Health Department employee by telling them "I want to file a complaint."

If you need help filling in the complaint form, any Health Department employee would be happy to help you.

Be sure to explain what happened and what you would like to see happen to resolve your complaint.

What happens ***after*** you file a complaint?

After your complaint is turned in, it will be reviewed. Within 5 days, we will send you a letter in the mail that includes a resolution to your complaint.

If your complaint cannot be resolved in 5 days, the letter will explain why we need more time to review and look into your concerns. We will respond to your complaint with a resolution within 30 days from the day you submitted the form.

All complaints, related information, and resolutions will be sent to the Health Department's Quality Improvement Committee for review. This committee includes consumer representation.

What do you do if you are unhappy with the resolution?

If you are still not satisfied with the resolution, you may discuss your situation further with the appropriate Team Supervisor, Program Supervisor, or Division Director.

You may appeal any resolution by following the instructions on the letter you will receive:

MVBCN clients can appeal by contacting the Department of Human Services Addictions and Mental Health Division at 503-947-5528.

Non-MVBCN clients can appeal by writing to the Health Department Administrator within 10 days. If you would like assistance with your appeal, you can contact your counselor or the Quality Assurance Coordinator at 503-576-4509.

Revised 4/13/2011. This revision replaces any previous language.

Marion County Health Department

Notice of Privacy Practices

Effective Date: June 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS IS YOUR RIGHT TO NOTICE.

This Notice is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA). Contact your Service Provider, or call the general number for the Health Department at: Phone 503-588-5357, or Fax 503-364-6552.

In this Notice, the words "we," "us," "our," and "Department" mean the Marion County Health Department.

The Purpose of this Notice

The Department provides many types of services, such as medical care and mental health services. Department staff must collect information about you to provide these services. The Department knows that information we collect about you and your health is private. We are required to protect this information by federal and state law. We call your individual health information "protected health information" (PHI).

This Notice of Privacy Practices will tell you how the Department may use or share information about you. Not every situation may be described. If you have any questions about any statements in this notice, please feel free to ask your Service Provider. The Health Department is required by law to make a copy of our notice of privacy practices available to you at your request. By law, we must follow the terms of the notice currently in effect.

How We May Use and Share Your Information

■ **For Treatment.** The Department may use or share information with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.

■ **For Payment.** The Department may use or share information to get payment or to pay for the health care services you receive. For example, we may provide your health information to bill your heath plan for your medical visit here.

■ **For Health Care Operations.** The Department may use or share information in order to manage its programs and activities. For example, we may use information to review the quality of services you receive.

■ **In Organized Health Care Arrangements**. We may use and share health information with organizations such as the Marion County Integrated Delivery System, HIV Alliance, and the Behavioral Care Network. We participate in joint health care activities such as ensuring continuing care for you.

■ **In the State Certified Coordinated Care Organization.** We may use and share health information with organizations involved in the Willamette Valley Community Health (WVCH). You can find a full list of involved participants posted in all department waiting rooms.

■ **For Appointment Reminders and Other Notifications To You.** The Department may call you or send you reminders for medical care or counseling visits with us. We will call you at the phone number you give us unless you tell us to call you at a different phone number. You can also tell us not to call you at all.

■ **For Public Health Activities.** The Department is the public health agency that keeps and updates vital records, such as births, deaths, and some communicable diseases.

■ **For Health Oversight Activities.** We may use or disclose your information during inspections or in investigations of our service.

■ **For Law Enforcement or Courts.** The Department will use and share information when required or permitted by federal or state law or by a court order.

■ **For Abuse Reports and Investigations.** We are required by law to receive and report abuse and neglect to proper state authorities. This may result in a PHI disclosure.

■ **For Government Programs.** The Department may use and share information for public benefits under other government programs. For example, we may share your information to check eligibility for a nutrition program such as WIC.

■ **For Coroners, Medical Examiners and Funeral Directors.** We may disclose information for the identification of a deceased person, and other activities permitted by law.

- **To Avoid Harm and Special Government Activities.** The Department may share PHI with law enforcement or the US government in order to avoid a serious threat to the health or safety of any person, the public in general or for protection of the President.
- **For Research.** The Department uses PHI for public health studies and some reports. These studies and reports do not identify specific people.
- **For Fundraising.** The department will not use any of your information for fundraising purposes.
- **For Facility Directories.** The Department does not maintain a facility directory.
- **For Workers' Compensation.** We may disclose your health information to comply with laws for workers' compensation or similar programs.
- **Sharing Your Information with Family, Friends and Others.** We may share health information with your family or other persons you have identified as involved in your medical or mental health care. You have the right to object to the sharing of this information.

Other Uses and Disclosures that Require Your Written Authorization

Marketing. We must obtain your authorization prior to using your health information to send you any marketing materials. We can though provide you with marketing materials face-to-face or give you a gift of nominal value without your authorization. In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without your authorization.

Other Laws Protect Your Health Information

Many Department programs have other federal and state laws to follow for the use and disclosure of your information. These will require your authorization. For example, you must give your written authorization for us to share your mental health and alcohol or drug treatment records. Types of health information that have special privacy protections include, but are not limited to: treatment of a mental illness and session therapy notes, alcohol and drug abuse treatment services, HIV/AIDS testing and services, and genetic testing.

Your Health Information Privacy Rights

As a client of the Department, you are afforded the following rights:

- **Right to See and Receive Copies of Your Records.** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.
- **Right to Request Correction or Amendment to Your Records.** You may ask to change or add missing information to your records, if you think there is a mistake. You must make the request in writing and provide a reason for your request. We may deny your request. If we deny your request, we will send you a letter that tells you why your request is denied and how you can ask for a review of the denial.
- **Right to Request an Accounting of all Disclosures.** You have the right to ask the Department for a list of non-routine disclosures and routine disclosures made electronically within three years prior to the date of request. You must make the request in writing. You can request this type of list once per year.
- **Right to Request Limits on Uses or Disclosures of Your Information.** You have the right to ask that the Department limit how your information is used or shared. You must make the request in writing and tell us what information you want to limit and/or to whom you want the limits to apply. We are not required to agree to the limitation. You can request that the limitation be terminated in writing or verbally.
- **Right to an Access Report.** You have the right to ask the Department for the access report that documents the particular persons who electronically accessed and viewed your protected health information. You must make the request in writing.
- **Right to Restrict Uses and Disclosures of PHI to a Health Plan when You Pay In Full Out of Pocket.**
- **Right to Revoke an Authorization.** If you are asked to sign an authorization to use or share information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared. Exception: Alcohol & Drug clients have the right to verbally revoke authorizations.
- **Right to Choose How We Communicate With You.** You have the right to ask that we share information with you in a certain way or at a certain place. For example, you may ask us to send information to your work address instead of your home address. Or, you may ask us to call you at a different phone number. Generally, you must make this request in writing. You do not have to explain why.

- **Right to File a Complaint.** You have the right to file a complaint if you do not agree with how the Department has used or shared your health information or if you disagree with our privacy practices in general.
- **Right to Receive or Decline a Paper Copy of This Notice.** You have the right to ask for a paper copy of this notice at any time.
- **Right to be Notified of a Breach.** You have the right to be notified if we (or a business associate) discover a breach of your unsecured health information.

For More Information and How to Contact Us

You may contact your Service Provider or the Health Department Privacy Officer at any time if you have a question about this notice or need more information on how to use your rights. Please use the address and phone number below.

Marion County Health Department **Privacy Officer** 3180 Center Street NE Salem, OR 97301 Phone number: 503-588-5357 http://www.co.marion.or.us/HLT/hipaa.htm	**Office for Civil Rights – Region X** **U.S. Department of Health and Human Services** 2201 Sixth Avenue – M/S: RX-11 Seattle, WA 98121-1831 Phone: 800-368-1019 • TTY: 800-537-7697 • FAX: 206-615-2297 Email: OCRComplaint@hhs.gov

How to File a Complaint or Report a Suspected Problem

You may contact us or the US Department of Health and Human Services (DHHS) as listed above if you want to file a complaint or to report a problem with how the Department has used or shared information about you. The services we provide will not be affected by any complaints you make. The Department cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

Duration of This Notice

We may change the terms of this notice at any time. Any changes will apply to information we already have, as well as any information we may receive in the future. A copy of the new notice will be posted at each Health Department Service Provider site and provided as required by law. You may ask for a copy of the current notice anytime you visit a Health Department site, or you may get a copy on-line at: **http://www.co.marion.or.us/HLT/hipaa.htm**

Effective Date: June 1, 2013