You have certain rights regarding your health record information, as follows:

1. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
2. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
3. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
4. You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
5. All requests for inspection, copying, and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
6. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment, healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
7. If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice for your personal records.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.3

All questions concerning this Notice or requests made pursuant to it should be addressed to PRIVACY OFFICER, 1950 Keene Rd, Building K, Richland, WA 99352

(Keep for your files to use when needed)

1950 Keene Rd. Building K, Richland, WA. 99352 | p. 509-420-3442 | f. 858-521-8173 | www.childenrichmentcenter.org

Exhibit G

Receipt of Notice of Privacy Practices

Child's Name:_____ Date of Admission(today): _____

My signature on this form acknowledges that I have received Child Enrichment Notice of Privacy Practices. I understand that this document explains the ways that Child Enrichment Center may use or disclose my child's personal information and my child's rights with respect to my child's service information.

I have been provided with the opportunity to discuss any concerns about the privacy of my child's information Child Enrichment Center has during the provision of services.

Signature of Parent/Legal Guardian Date

Child Enrichment Center Representative Date

(Copies of these completed and signed forms are in your child's file).

1950 Keene Rd. Building K, Richland, WA. 99352 | p. 509-420-3442 | f. 858-521-8173 | www.childenrichmentcenter.org

Exhibit H

Consent to Release and/or Obtain Client Information

This consent form is designed to allow us to exchange information with other health care providers involved in the client's care. This will allow us to either obtain relevant records to help us provide thorough and complete care to the client and/or allow us to share records with other providers in order to coordinate care.

Client's Name:_____DOB:_____Telephone #: _____

Treatment Services Received at Child Enrichment Center:_____

☐ Obtain Information £ Release Information

The purpose of this disclosure:
☐ Coordination of Care
☐ At client/parent request
☐ Other (specify): _____

This authorization expires on (insert date): _____

Note: If no expiration date is listed above, this authorization is valid for three years from the date on which it is signed.

Outside Provider Contact Information
Name of Provider: _____
Organization: _____
Address: _____
Phone#: _____ Fax#: _____

Email: _____

☐ Obtain Information ☐ Release Information

Information that is authorized to be released or obtained from the above provider: (please check all boxes that may apply)

☐ Treatment Summary ☐ Progress Notes ☐ Assessment Results ☐ Verbal Disclosure
☐ Past or Present Treatment/Service Plans ☐ Evaluation Report ☐ Medical/Health Information
☐ Psychological Testing ☐ Individual Education Plan (IEP) ☐ Other: _____

POTENTIAL FOR REDISCLOSURE: Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information.

REVOCATION: I understand that I may revoke this authorization by submitting the revocation request in writing to the Child Enrichment Center Privacy Office, 1950 Keene Rd, Building K, Richland, WA 99352, at any time. Any revocation will not be effective to the extent that action has already been taken based on the original authorization, or where the Child Enrichment Center requires the information in order to be paid for treatment provided to me.

1950 Keene Rd. Building K, Richland, WA. 99352 | p. 509-420-3442 | f. 858-521-8173 | www.childenrichmentcenter.org

Authorization of the Child Enrichment Center to Disclose Protected Healthcare Information

By signing,
I acknowledge that I have read and agree to all the conditions specified in this consent form. I acknowledge the permission I give to Child Enrichment Center to release and obtain the information with specified providers as stated above and further understand: Those who receive this information cannot disclose it to others, unless permitted by state law.

This consent was made freely, voluntarily and without coercion.
I was able to ask questions and receive answers about this release.
I hereby authorize releasing and obtaining the information as specified above and further understand: Those who receive this information cannot disclose it to others, unless permitted by state law.
I understand the risks and benefits of disclosure:

- Benefits – Appropriate sharing of necessary information important for services
- Risks – Loss of confidentiality

I understand that I have the following rights:

- To inspect or to receive a copy of my protected health information,
- To receive a copy of this signed authorization and
- To refuse to sign this authorization

Signature of Parent/Legal Guardian	Date
Child Enrichment Center Representative	Date
Signature of Client (if 13 years or older)	Date

(Copies of these completed and signed forms are in your child's file)