



Notice of Privacy Practices

Your Privacy Matters to Us

The Children, Youth and Families Department may collect health information, including mental health and substance abuse information, for the purpose of providing quality services to you. The people providing services to you may use your information or disclose it to others. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect your medical information. We are also required to abide by the practices described in this notice.

Uses and Disclosures of Health Information

We will generally get your written authorization before using or disclosing your health information outside the Children, Youth and Families Department. However, there are some situations, as described herein, when we **do not** need your written authorization before using your health information or sharing it with others.

We may share your health information with doctors, nurses, pharmacists and other treatment providers who are involved in providing health-related services to you, and they may, in turn, use that information to diagnose or treat you.

We may use or disclose your health information so that we can obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after you have been treated or to obtain prior approval for services.

We may use or disclose your health information in order to conduct our normal business operations. For example, we may use your health information to evaluate the performance of our staff in serving you, or to educate our staff on how to improve the care they provide for you.

We may use your health information when we contact you with a reminder that you have an appointment for treatment or to tell you of a related service that may be of interest to you.

We may use or disclose your health information in an emergency or for an important public need.

If you do not object, we may disclose your health information to a family member, relative, or close personal friend who is involved in your treatment or payment for that treatment. We may also disclose your health information to help notify or locate a family member or other person responsible for your care.

We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your authorization.

We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities.

We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence.

We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facilities and services.

We may disclose your health information if we are ordered to do so by a court or administrative hearing officer that is handling a legal matter or to persons authorized by a court to receive the information.

We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws;

- Identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime;
- Your death resulted from criminal conduct;
- To report a crime that occurred on our property; or
- To report a crime discovered during an offsite investigation as required by law.

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

We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they may deem necessary to carry out their military mission.

If you are a resident of a CYFD juvenile correctional facility or you are detained by a law enforcement officer, we may disclose your health information, if necessary, to provide you with health care, or to maintain safety, security and good order where you are being detained or to where you are being transferred.

We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner.

We may use or disclose your health information if we have removed any information that might reveal who you are.

We may disclose your health information to a person or company as required by the US Food and Drug Administration.

We will ask for your written authorization before using your health information or sharing it with others for **any other purpose**. For example, in order to participate in a research project.

Your Rights Regarding Your Health Information

You generally have the right to inspect and copy your health information. You may be charged for copying and mailing costs.

You have the right to request that we amend your health information if you believe it is inaccurate or incomplete.

You have the right to receive a list from us, called an "accounting list," which provides information about when and how we have disclosed your health information to outside persons or organizations. Many routine disclosures we make will not be included on the list, but the list will identify non-routine disclosures of your information. You may be charged a fee if you request more than one accounting within a 12 month period.

You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement.

You have the right to request that we contact you in a way that is more confidential for you, such as at work instead of at home.

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

You may request a paper copy of this notice, even if you have previously agreed to receive this notice electronically.

The **effective date** of this Notice of Privacy Practices is June 16, 2003. We may change our privacy practices from time to time. We may make the changed notice effective for health information we already have. If we change the notice, we will provide you with the revised notice, and the current notice will be available in all CYFD locations and on our website at www.cyfd.org.

If you believe your privacy rights have been violated, you may file a complaint with the **CYFD Privacy Office** at 1120 Paseo de Peralta, PO Drawer 5160, Santa Fe, NM 87502, telephone (505) 827-4345 or with the **Secretary of the Department of Health and Human Services** at 200 Independence Avenue SW, Washington DC 20201. Should you ever make a complaint, it will **not** be held against you.

Thank you for taking the time to read this important information. After you have carefully read the Notice, please sign the attached acknowledgment and return it to the CYFD Privacy Office at the address provided above or to any CYFD location.

New Mexico Children, Youth and Families Department

CYFD

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

Please print

CLIENT	Client Name (Last, First Middle) .	Social Security Number	Date of Birth (Month, Day, Year) / /
	Client Address (No. and Street, City, State, Zip Code) . .	Telephone Number. ()	

I acknowledge that I was offered or provided a copy of the New Mexico Children, Youth and Families Department's (CYFD) Notice of Privacy Practices effective April 14, 2003. I was given an opportunity to ask questions at the address or phone number listed on the Notice of Privacy Practice.

SIGNATURE	Signature of Client or Personal Representative	Date . / /
	If Signed by Personal Representative, Relationship to Client	

Please return the signed acknowledgement to the CYFD Privacy Office at the address printed below, or to the CYFD location which is providing services to you.

CYFD Privacy Officer, 1120 Paseo de Peralta, PO Drawer 5160, Santa Fe, NM 87502