Welcome. Thank you for choosing us and filling out the Client Information document.

If you wish to complete this document digitally please download and save it to your computer.

To return this document and other required documents:

- Email: nk_him@northkey.org
- Fax: 859-534-2627
- Bring to any office location

Other required documentation:

- ✓ Driver's License or Picture ID
- ✓ Insurance Cards
- ✓ Custody documentation
- ✓ Social Security Card
- ✓ Proof of Income

If you have already scheduled your first appointment, we look forward to meeting with you. If you need to schedule, please reach out to us at (859) 331-3292 and speak with our Access team.

If you feel that you are in Crisis, please call us at our 24 hour Access and Crisis line at (859) 331-3292. We are happy to be of help.

Best wishes from the NorthKey Community Care team.

NorthKey
COMMUNITY CARE

Client Information:

First Name: _____
Middle Name: _____
Last Name: _____
SSN: _____ Date of Birth: _____

Sex at Birth:
◯ Female ◯ Male

Do you identify with a gender other than the one you were born?
◯ No
◯ Yes - Male
◯ Yes - Female
◯ Yes - Transgender Male (designated female at birth but identifies as male)
◯ Yes - Transgender Female (designated male at birth but identifies as female)
◯ Questioning or Don't know
◯ Choose not to disclose
◯ Yes – Intersex (at birth, had biological characteristics /reproductive organs associated with both male and female sex)
◯ Yes – Nonbinary or Genderqueer (identifies with or expresses a gender that is neither exclusively male nor female)

Physical/Living Address: _____ Apt #: _____
City: _____ County: _____
State: _____ Zip: _____

Primary Phone #: _____ Home:◯ Cell:◯ Other:◯
Is it Ok to leave a message?
◯ No ◯ Yes

Alternate Phone #: _____ Home:◯ Cell:◯ Other:◯
Is it Ok to leave a message?
◯ No ◯ Yes

Email Address: _____

Where are you living?
◯ Alcohol/Drug Treatment Facility
◯ Boarding Home
◯ Family Care Home
◯ Foster Care
◯ Homeless/Uninhabitable Dwelling
◯ Hotel/Motel
◯ ICF/MR Private Facility
◯ ICF/MR State Facility
◯ Jail/Prison Federal
◯ Jail/Prison Local State
◯ Mission/Shelter
◯ Personal Care Home
◯ SNF (Nursing Home)
◯ Staffed Residence
◯ Living in Own Residence
◯ Living in Parent/Guardian Residence
◯ Living in Own Residence with Parent/Guardian
◯ Living in Residence of a Family Member Other than Parent/Guardian
◯ Living in Residence of Friend/Acquaintance

Marital Status:

- ◯ Single/Never Married (Only Marriage was Annulled)
- ◯ Married
- ◯ Divorced
- ◯ Co-habitating
- ◯ Widowed
- ◯ Separated

Are you now, or have you been homeless in the past 12 months?

- ◯ No
- ◯ Yes

Military History:

- ◯ No Military Service
- ◯ Active Duty without Deployment
- ◯ Active Duty with Deployment to Non-Combat Zone
- ◯ Active Duty with Deployment to Hostile or Combatant Zone
- ◯ Previous Duty without Deployment (Veteran)
- ◯ Previous Duty with Deployment to a Non-Combatant Zone (Veteran)
- ◯ Previous Duty with Deployment to a Hostile or Combatant Zone (Veteran)

Are you a registered voter?

- ◯ Child - not applicable
- ◯ No
- ◯ Yes
- ◯ No – Please reach out to me for help registering to vote
- ◯ No – Please send me a voter registration card in the mail

Do you have a hearing (auditory) impairment?

- ◯ No Impairment
- ◯ Hard of hearing
- ◯ Unknown
- ◯ Deaf/Blind
- ◯ Deaf

Primary Language Used:

- ◯ American English
- ◯ Afro-Asiatic
- ◯ American Sign Language
- ◯ North American Indian
- ◯ Chinese
- ◯ French
- ◯ German
- ◯ Italian
- ◯ Japanese
- ◯ Korean
- ◯ Hebrew
- ◯ Arabic
- ◯ Russian
- ◯ Polish
- ◯ Spanish
- ◯ Vietnamese
- ◯ Other

Ability to understand English language:

- ◯ English is Primary Language
- ◯ Not at All
- ◯ Not Well/Poorly
- ◯ Very Well (Above Average for Age)
- ◯ Well (Average for Age)

Do you identify with any of the following Ethnicities or Hispanic Origins?

- ◯ Cuban
- ◯ Mexican
- ◯ Not of Hispanic Origin
- ◯ Other Hispanic
- ◯ Puerto Rican

Race – *please check any that apply:*

- ☐ White/Caucasian
- ☐ African American
- ☐ American Indian/Alaskan Native
- ☐ Asian (including Japanese Americans)
- ☐ Native Hawaiian/Pacific Islander

Current School Name: _____

Have you attended school or college in the past 3 months?

- ◯ No
- ◯ No because Client's School/College was on Break During the Last Three Months
- ◯ Yes, Client has Attended Public School, Private School, Home School, College or University
- ◯ Yes, Self-Contained Special Education Class for Children in Special Education Not mainstreamed in Regular School Grade

Highest Level of Education/Last Grade Completed:

- ◯ No schooling
- ◯ Pre-School completed
- ◯ Kindergarten completed
- ◯ First grade completed
- ◯ Second grade completed
- ◯ Third grade completed
- ◯ Fourth grade completed
- ◯ Fifth grade completed
- ◯ Sixth grade completed
- ◯ Seventh grade completed
- ◯ Eighth grade completed
- ◯ Ninth grade completed
- ◯ Tenth grade completed
- ◯ Eleventh grade completed
- ◯ High school graduate/GED completed
- ◯ 1 year of education beyond high school completed
- ◯ 2 years of education beyond high school completed
- ◯ 3 years of education beyond high school completed
- ◯ 4 year college degree completed
- ◯ 1 year of education beyond 4 year college degree completed
- ◯ 2 years of education beyond 4 year college degree completed
- ◯ 3 years of education beyond 4 year college degree completed
- ◯ 4 years of education beyond 4 year college degree completed
- ◯ 5 years of education beyond 4 year college degree completed
- ◯ 6 years of education beyond 4 year college degree completed
- ◯ 7 years of education beyond 4 year college degree completed
- ◯ 8 years of education beyond 4 year college degree completed
- ◯ More than 8 years of education beyond 4 year college degree completed
- ◯ Education level unknown
- ◯ Education level not applicable/collected

Mother's Full Maiden Name: _____

Father's Full Name: _____

Responsible Party:

◯ Self ◯ Parent (client is minor under 18) ◯ Guardian

Responsible Party Name: (*only if different than self):* _____
Responsible Party Address:(*only if different*): _____
Apt #: _____ City: _____ County: _____
State: _____ Zip: _____

Emergency Contact:

Who may we try to contact in case of an emergency and leave a message?
#1 Emergency Contact: _____ Phone #: _____
#2 Emergency Contact: _____ Phone #: _____

Custody/Guardianship arrangements:

Select below any type of Custody or Guardianship arrangements. Note in some situation's documentation will have to be faxed/emailed to NorthKey's Health Information Department or can be dropped off at any NorthKey office location.

Fax # 859-534-2627 Email: nk_him@northkey.org

◯ **Self: (**no documentation needed)
◯ **Minor Living with Parents:** (no documentation needed)
◯ **Joint Custody:** Mom and Dad are divorced but share custody which allows either parent to make decisions about the child (DOCUMENTATION REQUIRED)
◯ **Guardianship**: Guardianship can be for an incapacitated senior, a minor, or for developmentally disabled adults. A guardian can be a variety of different people including grandparents, aunts, uncles, cousins, friends, or an agency (DOCUMENTATION REQUIRED)
◯ **DCBS/DAIL:** The Department for Community Based Services or Department for Aging and Independent Living has custody (DOCUMENTATION REQUIRED)
◯ **Power of Attorney – Medical:** The client has a POA that allows the named person to make medical/mental health decisions about care on their behalf (DOCUMENTATION REQUIRED)
◯ **Sole Custody of Mother:** Mom has sole custody (DOCUMENTATION REQUIRED)
◯ **Sole Custody of Father:** Dad has sole custody (DOCUMENTATION REQUIRED)
◯ **Temporary order:** A temporary custody order is in place (DOCUMENTATION REQUIRED)

Income/Billing/Insurance Information:

What is the number of dependents you are responsible for? *This number would include you, your spouse, and any dependents under the age of 18 in the household for whom you are the primary caregiver)* #_____

What is the primary source of income for the household?

◯ Disability ◯ Public Assistance ◯ Wages/Salary/Self Employed
◯ No Income/Support ◯ Retirement/Pension
◯ Other Sources

Do you or any of the dependents within the household receive SSI or SSDI?

◯ No- Receives None ◯ Yes- SSI Only
◯ Yes- Both SSI and SSDI ◯ Yes- TANF and SSDI
◯ Yes- SSDI Only ◯ Yes- TANF Only

Employment Status:

◯ Child, Preschool, Under Age 6 ◯ Laid Off from Job
◯ Disabled ◯ Looking for Work/Available for Work During the Last Four Weeks/Not looking for work
◯ Employed Full Time 32 or More Hours Per Week ◯ Resident of Institution/Incarcerated
◯ Employed Part Time 31 or Less Hours Per Week ◯ Retired
◯ Homemaker ◯ Student
◯ In the Armed Forces

Place of Employment: _____

Income Frequency:

◯ Weekly ◯ Monthly
◯ Bi-weekly (every other week) ◯ Quarterly (every three months)
◯ Bi-monthly (twice per month, example: 1st & 15th of each month) ◯ Yearly

What is the total annual household income? This would include SSI/SSDI, employment or other income received in the household: $_____

Insurance Information:

☐ *Please check this box if you have no insurance. A member of our billing team will reach out to help you.*

Medicaid Number: _____

Insurance Company:_____
Insurance Company Phone #:_____
Policy #: _____ Group #: _____

Policy holder info – only needed if policy holder is not client
Name: _____
DOB: _____ SSN:_____

Additional Comments Regarding Insurance if needed:

_____

_____

_____

_____

Primary Care Physician

Please fill in below physician's name/group, address if known (or city), phone & fax if known.

Name of Physician/Group: _____

Physician's Address: _____

Physician's Phone #: _____ *Fax #:* _____

I authorize NorthKey Community Care to communicate with my Healthcare provider for the express purpose of improving the quality and coordination of my care. I understand that this communication may include initial and quarterly summaries over the course of my treatment to help ongoing communication about my healthcare treatment. I consent to the release of all substance use disorder information. This consent will remain in force for one year and may be revoked at any time except to the extent that the part 2 program has already acted on it. 42 CFR part 2 prohibits unauthorized disclosure of these records.

If you do not have a PCP, NorthKey will send you information about Primary Care services. Choosing a primary care physician is an important decision, as your doctor is your advisor and partner in helping you maintain good health. At NorthKey, we encourage communication between physical health and behavioral health providers to improve the quality and coordination of care.

Advance Directive:

A psychiatric advance directive is a legal document that allows you to note your preferences for treatment in advance of a mental health crisis.

Do you have a Psychiatric Advance Directive?

◯ Child - not applicable
◯ Yes
◯ No
◯ No – Please reach out to me to share information about Advance Directive

If you have a psychiatric advance directive, please fax, or email a copy to our Health Information Department or drop it off at any NorthKey location.

Fax # 859-534-2627 Email: nk_him@northkey.org

Appointment Text/Email Reminder Notifications:

Notification will be sent 1 business day before scheduled appointment.

◯ Text
◯ Email
◯ Text & Email
◯ Not Interested

General Acknowledgement/Consent for Treatment & Billing:

I certify that I have reported all insurance policy/plans to NorthKey Community Care. I agree to notify NorthKey Community Care of any changes in my healthcare insurance coverage and agree to bring any such insurance cards with me to each appointment. I hereby assign and authorize direct payment of my medical benefits to NorthKey Community Care. I authorize the use of electronic signature on file to be used in all insurance claim submissions. I authorize NorthKey Community Care to release all medical and other information to third-party payers, benefit administrators, or other persons as necessary to verify benefits, to authorize medical services to be received, to process claims for benefits, I understand that NorthKey will use grant funds whenever possible. In order to improve the quality of services, data is collected and reported to Substance Abuse and Mental Health Services Administration (SAMHSA). This information is de-identified prior to submission.

I am acknowledging that I am either the person listed on these documents consenting to treatment or the authorized legal guardian, authorizing NorthKey Community Care to give treatment and/or services. I acknowledge that I have reviewed the Notice of Privacy Practices and the Informational section of this document. If I have questions or would like more information I can view and print the below documents from NorthKey Community Care's website or contact a representative at NorthKey Community Care to ask questions.

Privacy Practices – HIPAA Notice
Client Rights/IDD Client Rights
Confidentiality statement
Client Grievance Procedure
Sliding Scale Fee

Client Name: _____

Client Signature: _____ Date: _____ Time: _____

Guardian Name: _____

Guardian Signature: _____ Date: _____ Time: _____

If signing electronically by PDF Please sign below and email document to nk_him@northkey.org by clicking on the email address :

DISCLAIMER: By typing your name below, you are signing this document electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this document.

Please type your name: _____

Client/Guardian electronic signature: _____

Do not forget to complete a Release of Information for anyone that you would like NorthKey to share information with.

This could include family, friends, school, attorney, social workers, payee, or other healthcare workers involved in your care? For minor children, complete a release of information for anyone who may bring your child to an appointment in the future.

For Informational Purposes:

Confidentiality

Confidentiality is a critical part of the therapy relationship, which is carefully protected by law. This means that information you share with your therapist cannot be divulged to anyone except other staff of this agency, without your permission. If you do choose to release information, that information cannot be provided to any further party without your permission. There are several specific circumstances under which we must break confidentiality and divulge information because the law requires us to do so. Please visit our website to review our Confidentiality Statement.

Medication Eligibility

If I receive medication management services, my provider may check to make sure the medication prescribed to me are covered by my insurance company. To obtain this information, NorthKey Community Care may access my insurance coverage information via their electronic health record.

Telehealth Services

NorthKey may offer to provide service through a Telehealth videoconference with a clinician. Telehealth services are delivered through a secure transmission and that NorthKey Community Care will make every effort to ensure that all information about my Telehealth encounter is kept safe and private. If I am uncomfortable with the use of videoconferencing technology, at any time, I may stop the videoconference and request that a traditional, in-person clinical visit be scheduled. I understand that all laws about the privacy and security of my Personal Health Information (PHI) as outlined by HIPAA, apply to Telehealth services as they do to all other applicable services delivered by NorthKey. I understand that I am not under obligation to receive services only by Telehealth, and that I can choose to receive traditional in-person services instead.

No Show/Cancellation Review

Your overall health and involvement with services at NorthKey Community Care is very important to us. To maximize benefits of supportive services, attending scheduled appointments is very important.

Please review the following responsibilities for appointment attendance:

- ✓ *When I am not going to attend my scheduled appointment, I will give 24-hour notice of the cancellation.*

NorthKey will assume I am no longer interested in continuing services:

- ✓ *If I do not call to schedule a 2nd appointment and/or if I do not attend my 2nd appointment.*
- ✓ *When it has been more than 3 months since my last attended appointment, and I have no future appointments scheduled.*

Crisis Services

No parental consent is needed for mental health services by a professional to any minor if the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment. The minor must be in a crisis and is in urgent (immediate) need of mental health services. This would NOT include ongoing mental health therapy, but rather, a one-time service to treat the immediate mental health crisis. Ongoing mental health services (that are not considered a crisis) would require parental consent. KRS 214.185(4).

Client Rights & Responsibilities
When you receive services from NorthKey Community Care you have certain rights and responsibilities. One of these rights is that you be informed of your rights upon initiation of services. More information about your rights and responsibilities is available on NorthKey Community Care's website.

Grievance Process
A grievance can be filed on any potential client rights violation. The grievance process may be started by calling the Chief of Services and Development. The grievance may also be started by the client's request for a Grievance Information form at any NorthKey location. At any point in the process, the person filing the grievance may contact NorthKey Community Care's Ombudsman to help individuals in resolving complaints.

Notification of follow-up
Representatives of NorthKey Community Care may contact you during treatment and/or following termination from treatment to find your satisfaction with the services received at this organization.

Language Assistance
I understand that NorthKey will supply language services at no charge to me. I understand that the language services may be provided to me by a contracted interpreter.

TB Skin Tests
Tuberculosis (TB) is on the rise in the United States. As part of your treatment with this agency we encourage you to obtain a TB Skin Test. Early detection of TB can be very beneficial, and treatment is very successful. TB skin tests are given daily at the local Health Department.

IV Drug Use
Individuals who have ever used IV drugs are at high risk for infection with HIV, Hepatitis, and TB. We encourage you to get tested for HIV, TB, and Hepatitis. Anonymous testing and HIV counseling is available at a small charge at your local Health Department. Staff at NorthKey can help you in accessing these services.

Pregnant females & prenatal care
It is very important for pregnant females to have regular visits with their physicians for their own personal health care and for prenatal care for their unborn child. Avoiding use of tobacco, alcohol, and other drugs that will harm the unborn child are also very important. NorthKey can help you in accessing these services.

NorthKey's Client Health Portal:
If you entered your email address on page one you will be signed up for NorthKey's Client Portal. You will receive an access key via email that will expire in 5 days. Please take advantage of this valuable healthcare resource.

If you do not receive your registration key within 2 business days of submission of this document, the key has expired, or you are unable to sign into your account please contact us at 859-331-3292.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

YOU HAVE THE RIGHT TO:

- Receive a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Receive a list of those with whom we've shared your information
- Receive a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ ***See page 2*** for more info on these rights and how to exercise them

Your Choices

YOU HAVE SOME CHOICES IN THE WAY THAT WE USE AND SHARE INFORMATION AS WE:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Provide substance use services
- Raise funds (only with your written permission)

➢ ***See page 3*** for more info on these choices & how to exercise them

Our Uses and Disclosure

WE MAY USE AND SHARE YOUR INFORMATION AS WE:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Respond to lawsuits and legal actions
- Address workers' compensation, law enforcement, & other government requests

➢ ***See page3 & 4*** for more info on these uses & disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Receive an electronic or paper copy of your medical record

- You can ask to see or receive an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if asked for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. **(Must provide legal documentation of proof).**
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the info on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Room 509F HHH Bldg. Washington, D.C. 20201, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- **Appointment Reminders:** Unless you provide us with alternative instructions we may send appointment reminders and other similar materials to your home.

*If you are not able to tell us your preference, **for example** if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses & Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you (with exception to Substance Abuse and HIV clients where permission is required).

***Example:** A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

***Example:** We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

***Example:** We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. ***For more information see:*** https://www.hhs.gov/hipaa/for-individuals/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse or neglect of a child or of an adult that needs assistance with activities of daily living
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: https://www.hhs.gov/hipaa/for-individuals/index.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice: **09/23/2013, Revised on 8/28/2020**
- Privacy Officer: Valerie Simons, RHIA
  503 Farrell Drive, Covington, KY 41011 (valerie.simons@northkey.org) / 859-578-3200
  Security Officer: David Penley –
  502 Farrell Drive, Covington, KY 41011 (dpenley@northkey.org) / 859-578-3200
- **Per the Federal Regulation 42 CFR, Part 2,** "We will never share any substance abuse treatment records without your written permission" with exception to what is allowed by regulations, see below.

- **<u>Uses and Disclosures of PHI from Alcohol and Other Drug Records Not Requiring Consent or Authorization:</u>** The law provides that we may use/disclose your PHI from alcohol and other drug records without consent or authorization in the following circumstances:
    - **When required by law:** We may disclose PHI when a law requires that we report information about suspected child abuse and neglect, or when a crime has been committed on the program premises or against program personnel, or in response to a court order.
    - **Relating to decedents:** We may disclose PHI relating to an individual's death if state or federal law requires the information for collection of vital statistics or inquiry into cause of death.
- **For audit or evaluation purposes:** In certain circumstances, we may disclose PHI for audit or evaluation purposes.
- **Health Information Exchange:** In order to support the best possible care among all your providers, there will be times when some basic information will be sent from one provider to another through a secure electronic communication. The information sent or received will include only essential components of your diagnosis and treatment. This information exchange is intended to assure that your care is consistent, and your providers are well informed in all settings. This secure electronic exchange does not require your consent, but we can exempt you from the exchange at your request. If you have concerns about secure electronic information exchange, you can speak to your provider.