Reset Print Instructions

DHS Oregon Department of Human Services

Authorization for Use and Disclosure of Information

Oregon Health Authority

This form is available in alternative formats including Braille, large print, computer disk and oral presentation.

Legal last name of client/applicant:	First:	MI:	Date of birth:
Other names used by client/applicant:			Case ID number:

By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

Section A

Release from one record holder: *(individual, school, employer, agency, medical or other provider)*	**Specific information to be disclosed:**	**Mutual exchange: Yes/No**
HIV Alliance	psych/social/medical information	Yes

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

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

Alcohol/drug diagnoses, treatment, referral: _____

Section B

Release to: ***(address required if mailed)*** **If releasing to a team, list members.**	**Purpose:**	**Expiration date or event*:**
(your agency name here)	Care Coordination	One year
		from date of
		client's
		signature

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

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health and drug/alcohol diagnosis, treatment, vocational rehabilitation records or referral information without specific authorization.

Section C

Full legal signature of individual or authorized personal representative:	Relationship to client: Self	Date:
Name of staff person ***(print)***:	Initiating agency name/location: HIV Alliance	Date:
Full legal signature of agency staff person making copies:	This is a true copy of the original authorization document.	
Print staff person name:		

Required information for the client

To provide or pay for health services: If the Department of Human Services (DHS) or Oregon Health Authority (OHA) 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 also 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 or OHA program or service not acting as a health care provider

This is a voluntary form. DHS or OHA cannot condition the provision of treatment, payment or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on 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.

Using this form

1. Terms used: Mutual exchange: A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. Team: A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. Assistance: Whenever possible, a DHS or OHA staff person should fill out this form with you. Be sure you understand the form before signing. Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an authorized person to sign on your behalf.
3. Guardianship/custody: If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody and their representative signs, their custody authority must be attached to this form.
4. Cancel: If you later want to cancel this authorization, contact your DHS or OHA staff person. You can remove a team member from the form. You will be asked to put the cancellation request in writing.
   Exception: Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. DHS or OHA can continue to use information obtained prior to cancellation.
5. Minors: If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. Special attention: For information about HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment, the authorization must clearly identify the specific information that may be disclosed and the purpose.

Redisclosure: Federal regulations (42 CFR part 2) prohibit making any further disclosure of alcohol and drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.

Note: Oregon's health services and programs have been transferred from the Department of Human Services (DHS) to the Oregon Health Authority (OHA). DHS will continue to determine eligibility for many of the health programs, as well other programs administered by DHS.

HIV ALLIANCE POLICIES AND PROCEDURES
Dept: Entire Agency
Subject: Client Grievances
Page 1 of 3 **Effective 4/30/02, revised 2016**

Policy:

Clients shall have the right to file a grievance, have an investigation and review of the grievance by responsible persons at the agency, have the agency make a decision concerning a grievance and appeal the decision if the resolution is not satisfactory to the client.

Intent:

HIV Alliance takes client grievances very seriously. The procedures shall allow a full airing and opportunity for resolution of client grievances, while encouraging informal problem solving and resolution.

Procedures:

1. Client complaint & termination
   - 1.1. A client's verbal complaint is sufficient to trigger the client grievance process
   - 1.2. Client complaints and grievances should be **immediately** referred by volunteers to a relevant staff person
   - 1.3. Staff members who receive a complaint shall **immediately** ask whether the client wishes to file a grievance
   - 1.4. If so, staff will ask whether the client wishes to complete a Client Grievance Form or whether the client wishes the staff to complete the form for them
     - 1.4.1. If staff complete the Client Grievance Form on behalf of the client, the client shall date and sign the form signifying the accuracy of the information about the grievance
   - 1.5. The staff member will **immediately** explain the grievance process
   - 1.6. The Client Grievance Form will document the following information:
     - 1.6.1. How can we get in touch with you? (Name/address/phone/place to leave message)
     - 1.6.2. Verifies exactly what complaint is – who, what, when, where
     - 1.6.3. Asks what resolution the client is looking for
     - 1.6.4. Date and client signature signifying the accuracy of the information
   - 1.7. If the client chooses not to file a grievance, staff will document the complaint as an incident report (See Incident Report Policy and Procedure)

2. Client Termination
   - 2.1. Clients who are terminated from HIVA services will have the opportunity to file a grievance
   - 2.2. Clients will be provided with the grievance policy and form when they are notified in writing of their termination from service
   - 2.3. Clients must file a termination related grievance within 15 days of the termination date
   - 2.4. If the full grievance process available through HIV Alliance does not resolve the issue, the client has the right to a hearing in accordance with ORS chapter 183.

2.4.1. The written notification of the final grievance response will include the following language:

"You are entitled to a hearing as provided by the Administrative Procedures Act (chapter 183, Oregon Revised Statues). If you want a hearing, you must complete an Administrative Hearing Request form (MSC 0443) within 15 days from the date of the grievance response letter. You may mail your request for hearing to 800 NE Oregon St. #1105 Portland, OR 97232 or fax it to 503-673-0177. If your request is not received within the timeframe, your right to a hearing shall be considered waived."

3. Notification to relevant agency personnel
   - 3.1. **Within 3 working days of the filing of the grievance**, relevant agency personnel will be notified
     - 3.1.1. If the grievance is filed directly with a staff member, the staff member will give a copy of the Client Grievance Form to their supervisor; the supervisor will notify Executive Director
     - 3.1.2. If complaint is made to a supervisor, supervisor will notify relevant staff and the Executive Director
     - 3.1.3. If complaint is made to the Executive Director, the Executive Director will notify relevant staff and supervisors

4. Acknowledgement of grievance and initiation of grievance process
   - 4.1. **Within 5 working days of grievance being made**, written copies of the Client Grievance Form shall placed in
     - 4.1.1. The client's file
     - 4.1.2. The agency grievance file
   - 4.2. **Within 5 working days of grievance** being made, the supervisor will contact the client in person, by phone or in writing to
     - 4.2.1. Acknowledge the filing of a grievance
     - 4.2.2. Give the client a copy of the Client Grievance Form
     - 4.2.3. Explain the grievance policy and procedures and give the client a copy of this policy
     - 4.2.4. Give the client a choice of informal or formal resolution, encouraging informal resolution
     - 4.2.5. Schedule a time, within 30 days, for the informal or formal resolution meeting or set out times for client to pick for either informal or formal resolution
     - **4.2.6. In situations where the normal timelines for responding to formal grievances is too long, and may present harm to the individual seeking to file a grievance, our policy is to expedite the process. Under these circumstances, the Program Director or Executive Director shall respond in writing within 48 hours. If you feel that this is the case in your situation, please make sure to request and expedited grievance and state the reason(s) that the normal response time is not sufficient.**
   - 4.3. If a letter is sent, copies will be filed in
     - 4.3.1. The client's file
     - 4.3.2. The agency grievance file
   - 4.4. If the supervisor talks to the client in person or by phone, the supervisor will document the information in 3.2 above and file copies in
     - 4.4.1. The client's file
     - 4.4.2. The agency grievance file

5. Informal resolution
   5.1. Informal resolution is encouraged and at the option of the client
   5.2. If client wishes to have an informal resolution meeting, a formal resolution meeting phase is postponed until the informal resolution attempt is completed
   5.3. If client is not interested in informal resolution, follow the procedures below for a formal resolution meeting
   5.4. Informal resolution means that the client can meet with the involved staff and supervisors to try to talk it out
   5.5. This meeting shall occur **within 30 days of receipt of client's oral or written request for informal resolution**, unless the time is extended due to the client
   5.6. If the matter is resolved, **within 5 days**, the supervisor shall make a written record with copies to
      5.6.1. The client's file
      5.6.2. The agency grievance file
      5.6.3. The Executive Director
      5.6.4. The client
   5.7. If the matter is not resolved, the grievance shall go to formal resolution

6. Formal Resolution
   6.1. A formal resolution meeting shall occur **within 30 days of receipt of the client's oral or written request for a formal resolution meeting**
   6.2. Supervisor will bring the parties together and explain the process for the formal resolution meeting, the decision and the possible appeals
   6.3. All parties will have an opportunity to explain their perspective and present information relevant to the grievance
   6.4. Supervisor may ask follow-up and clarifying questions
   6.5. Supervisor may ask for additional information and extend the meeting to another day and time
   6.6. Supervisor may verbally issue decision or allow time for consideration
   6.7. **Within 5 days of the formal resolution meeting,** the supervisor will issue a written decision which will include notification about the option to appeal to the Executive Director with copies to
      6.7.1. The client's file
      6.7.2. The agency grievance file
      6.7.3. The Executive Director
      6.7.4. The client

7. Appeal to Executive Director
   7.1. **Within 30 days of the supervisor's decision**, the client may appeal a supervisor's decision by making a written request for an appeal to the Executive Director
   7.2. Executive Director will interview all relevant parties by phone or in person
   7.3. Executive Director may opt to bring all parties together for another meeting
   7.4. **Within 30 days of receipt of the client's written appeal request**, Executive Director will issue a written decision which will include notification about the option to appeal to the Executive Committee with copies to
      7.4.1. The client's file
      7.4.2. The agency grievance file
      7.4.3. The Executive Director
      7.4.4. The client

8. Appeal to the Board of Director's Executive Committee
   8.1. **Within 30 days of the Executive Director's decision**, the client may appeal the Executive Director's decision by making a written request for an appeal to the agency's Executive Committee
   8.2. The Executive Committee will review the record which consists of
      8.2.1. The Client Grievance Form
      8.2.2. All other grievance correspondence, decisions and documentation in the agency's grievance file related to this grievance
   8.3. A member of the Executive Committee will talk to the client
   8.4. **Within 30 days of receipt of the client's written appeal request**, the Executive Committee will issue a written decision with notification about option to appeal to the Board President with copies to
      8.4.1.The client's file
      8.4.2. The agency grievance file
      8.4.3. The Executive Director
      8.4.4. The client

9. Appeal to Board President
   9.1. **Within 30 days of the Executive Committee's decision**, the client may appeal the **Executive Committee's** decision by making a written request for an appeal to the President of the Board
   9.2. President will review the record only

   9.3. **Within 30 days of receipt of the client's written appeal request**, the President will issue a written decision with notice that the decision is final and there are no more avenues of appeal with copies to
      9.3.1. The client's file
      9.3.2. The agency grievance file
      9.3.3. The Executive Director
      9.3.4. The client

HIV Alliance

Client Grievance Policy
Termination Policy

1. I have been given a copy of the HIV Alliance Client Grievance Policy.
2. I have been given a copy of the HIV Alliance Client Termination Policy.
3. I was given an opportunity to ask any questions I had about them.
4. I am clear that the Grievance Policy is available for my use as a client of HIV Alliance.
5. I know that HIV Alliance staff members are available to answer my questions regarding these policies, if I have them in the future.
6. I know that if I have a grievance with anyone within the agency I have the right to use the grievance policy as it is in the packet I received.
7. I understand that the Client Services Manager can terminate the services I receive here due to the circumstances outlined in the Termination policy.
8. I understand that if I am terminated I have the right to file a grievance. If the grievance does not resolve the issue I have the right to a hearing per ORS 183.

_____ _____

Client Signature Date

I have provided the above client with copies of Grievance and Termination policies, explained it briefly and offered to answer any questions now or in the future.

_____ _____

Case Manager Date

Client Name _____ Client ID _____

The Alliance
Ryan White Care Coordination Center
1195 City View St, Eugene, OR 97402
541-342-5088 or 1-866-935-9663, Fax 541-342-1150

Client Rights & Responsibilities

Client Rights

Individuals applying for or clients enrolled in the HIV Case Management Program have the following rights:

- To receive HIV case management services free of discrimination based on race, color, sex, gender, ethnicity, national origin, religion, age, class, sexual orientation, physical or mental ability.
- To be informed about services and options available in the HIV Case Management Program.
- To have HIV case management services and other program records maintained confidentially in accordance with OAR chapter 943, division 14.
- To have access to a written grievance process provided by the agency.
- To receive language assistance services including access to translation and interpretation services, at no cost if the individual or client has limited English proficiency, in order to access HIV case management services.

Client Responsibilities

A client enrolled in the HIV Case Management Program is expected to:

- Participate in screening, assessment, care plan development and implementation activities;
- Provide accurate eligibility information at all times;
- Inform the case manager of changes in address, phone number, income, family size, legal name changes, or health insurance coverage within 15 days;
- Make and keep appointments, or cancel or change an appointment within 24 hours of the scheduled time.

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- To receive language assistance services including access to translation and interpretation services, at no cost if the individual or client has limited English proficiency, in order to access HIV case management services.

Client Responsibilities

A client enrolled in the HIV Case Management Program is expected to:

- To treat other clients and staff of this agency with respect and courtesy.
- Participate in screening, assessment, care plan development and implementation activities;
- Provide accurate eligibility information at all times;
- Inform the case manager of changes in address, phone number, income, family size, legal name change, or health insurance coverage within 15 days;
- Make and keep appointments, or cancel or change an appointment within 24 hours of the scheduled time

I understand the above information and I have received a copy for my records.

_____ _____

Participant Date Case Manager Date

HIV Community Services Program
Coordination of Care Information

The Oregon Health Authority (OHA) HIV Care and Treatment Program runs several programs that help people living with HIV/AIDS gain access to HIV-related medical care and other supportive services.

If you are a client of any of the following programs, **you are a client of the OHA HIV Care and Treatment Program**.

- CAREAssist (*Oregon's AIDS Drug Assistance Program).*
- Ryan White Program Part B-funded Case Management *(through your local HIV case manager)*, including financial assistance and State Managed Services.
- Oregon Housing Opportunities in Partnership *(OHOP).*

When you participate in any of these programs, we will collect information that includes, but is not limited to, information about your:

- Medical information, including HIV status, physician visit dates and lab results;
- Contact information, including name(s), address(es) and phone number(s);
- Demographic information, including your age, race and ethnicity;
- Sources and amounts of income, assets or financial assistance;
- Participation in our programs and other assistance programs in your community, including your case notes that describe your work with your HIV case manager, your OHOP Housing Coordinator and your CAREAssist worker;
- Case management screening, including information on mental health, substance abuse, HIV risk behaviors and social supports;
- Ongoing needs and your satisfaction with our programs and services.

We will also verify the information that we collect from you by collecting information from other sources, including information from:

- Other OHA and the Department of Human Services (DHS) programs, including assistance programs run by the Aging and People with Disabilities (APD); the Self-Sufficiency Programs (SSP); and the Public Health Division (PHD);
- The Oregon Employment Department, including information regarding your reported wages and earnings or any compensation received through the Unemployment Insurance Center;
- The Oregon Department of Motor Vehicles, including your current address;

OHA 8405 (10/14), replaces DHS 8405

- Any other publicly-available sources of information or specific sources of information that you have given us written permission to contact.

We use this information to:

- Determine whether you qualify for our programs and other assistance programs in your community;
- Provide program assistance *(including HIV case management, OHOP housing assistance and payment of health insurance premiums and drug copays)*;
- Advocate for you when you need help accessing food, transportation, housing, financial assistance or other social service programs that you may qualify for. This means we may contact agencies on your behalf to assist in coordinating services. However, we will never talk about your HIV status or other protected health information without your written consent;
- Offer you referrals to other assistance available in your community;
- Help us evaluate our programs, improve services and understand your needs;
- Attempt to contact you when you leave our programs or are lost to follow up;
- Meet the reporting requirements of the agencies that fund our program, such as the U.S. Health Resources and Services Administration (HRSA) and the U.S. Department of Housing and Urban Development (HUD).

Participating in the HIV Care and Treatment Program is voluntary. At any time you may cancel your participation in these services.

If you have questions regarding this information please contact the HIV Care and Treatment Program at 971-673-0144 or at 1-800-805-2313.

HIV Alliance RWCA Case Management

INFORMED CONSENT

Client Name _____ Client #_____

Program Description

I understand that I am being invited to voluntarily participate in a RWCA (Ryan White Care Act) Case Management Program to provide me with help in planning and managing my healthcare in relation to my HIV infection. As a participant, I have the benefit of having access to a well developed information and service network within the community. The intent of this program is to improve my access to services and help me with many decisions involved in living with HIV infection. Financial matters, health care access, and long term care issues are a few of the services I can expect or receive assistance with through this program. As a result of my participation in this program, information about my physical and social conditions pertinent to my HIV infection will be documented and periodically evaluated. Information about my use of medical, social and community services will be documented in the HIV Case Management database. The information collected will be used in reports for funding sources, my physician, and by HIV Alliance for the purpose of determining quality and cost effectiveness of care, as well as the overall effectiveness of the system in caring for persons living with HIV infection.

Confidentiality

All data obtained for this program will be confidential and my privacy will be strictly protected. No reports, except to me physician, will identify me in any way. Any other information will be accessed or released only with my written consent.

Voluntary Participation

I understand that my participation in this program is voluntary. I may withdraw my consent to participate at any time without affecting my medical care or benefits to which I am otherwise entitled.

Statement of Approval of Consent

I have read the above description of this program and I understand it. All of my questions have been answered to my satisfaction. I voluntarily consent to participate in the described program.

_____ _____ _____

Client Signature Date Staff Signature Date

HIV Alliance

This notice gives you information about the privacy practices of the HIV Alliance.

1195A City View
Eugene, OR 97402
(541) 342-5088
www.hivalliance.org

Notice of Privacy Practices

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.**

This information is called Protected Health Information (PHI). This "Notice of Privacy Practices" will tell you how HIV Alliance may use or disclose information about you. Not all situations will be described. HIV Alliance is required to protect your health information by federal and state law. HIV Alliance is required to follow the terms of the notice currently in effect. Information may be shared between HIV Alliance and Oregon Health Authority (OHA) to determine eligibility, coordinate your care, and for treatment, payment and health care options.

Your Choices
See pages 2 & 3 for information on your rights and how to exercise them.

Our Uses and Disclosures
See pages 4 & 5 for information on the uses and disclosure of your information.

Your Rights
See page 6 for information on your choices and how to exercise them.

Your Information.
Your Rights.
Our Responsibilities.

THIS PUBLICATION WILL BE FURNISHED IN A FORMAT FOR INDIVIDUALS WITH DISABILITIES UPON REQUEST BY TELEPHONING (541) 342-5088.

Your Choices

For certain health information, you can tell us your choices about what we share

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

Ask us to correct your medical record

- You may ask us to change or add missing information to the health records HIV Alliance has created about you if you believe there is a mistake.
- The request must be in writing and you must provide a reason for your request.
- HIV Alliance may deny your request in certain circumstances, but will let you know why in writing within 60 days.

Request a list of disclosures

- You have the right to ask HIV Alliance for a list of your PHI disclosures made after April 14, 2013.
- You may make the request in writing.
- This list may not include the times that information was disclosed for treatment, payment, or healthcare operations.
- This list will not include information disclosed:
  - -directly to you or your family or information that was sent with your consent
  - -in connection with an authorized or permitted use or disclosure
  - -for treatment, payment, or healthcare operations
- If you request a list more than once during a 12 month period, you may be charged a small fee.

Ask us to limit what we use or disclose

- You may ask HIV Alliance to limit how your health information is being used or disclosed.
- You must make the request in writing and tell HIV Alliance what information you want to limit and to whom you want the limits to apply.
- We may not be required to agree to the restriction.
- You can request in writing or verbally that the restrictions be ended.

Your Choices

For certain health information, you can tell us your choices about what we share

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

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. • We will make sure the person has this authority and can act for you before we take any action
Choose how we communicate with you	• You have the right to ask that HIV Alliance share PHI with you in a certain way or in a certain place. • For example, you may ask HIV Alliance to send information to your work address instead of your home address. • You must make the request in writing but you do not need to provide a reason for the request.
How to be notified of a breach in your confidentiality	• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
File a complaint if you feel your rights are violated	• You have the right to file a complaint if you do not agree with how HIV alliance has disclosed health information about you. • If you would like to file a complaint, you may do so by requesting a grievance form from any staff person and completing and submitting the form to any agency director. • You may also contact the Office of Civil rights, US Department of Health and Human Services. • HIV Alliance will not take any action against you for filing a complaint.
Additional PHI privacy rights	• If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment with your health insurer. • We will say yes unless a law requires us to share that information.
Get a copy of this privacy notice	• You may ask for a copy of this notice at any time

Our Uses and Disclosures

How do we typically use or share your health information?

HIV Alliance may use or disclose health information without your authorization for the following purposes under limited circumstances:

For treatment	• HIV Alliance may use or disclose PHI with healthcare providers who are involved in your healthcare. • For example, information may be shared to create and carry out a plan for your treatment.
For payment	• HIV Alliance may use or disclose PHI to get payment or to pay for the services you receive. • For example, HIV Alliance may communicate with your insurance programs to help pay your medical bills.
For healthcare operations	• HIV Alliance may use or disclose PHI in order to manage its programs and activities. • For example, HIV Alliance may use PHI to review the quality of services you receive.
For abuse reports and investigations	• HIV Alliance is required by law to receive reports of abuse.
Worker's compensation	• When required by worker compensation laws.
To avoid harm	• HIV Alliance may disclose PHI in order to avoid a serious threat to your health and safety, or to avoid a serious threat to the health and safety of another person or the public.
If we need to disclose your information for any other reason we will first obtain your permission	• You may revoke this permission at any time, however the revocation will not apply to previous permitted releases of information. • If we disclose your information based upon your written permission, it may be re-disclosed by the receiving party. • Federal and State law may restrict the re-disclosure of certain information such as HIV/AIDS information, drug and alcohol information, genetic information, and mental health information.

Our Uses and Disclosures

How do we typically use or share your health information?

HIV Alliance may use or disclose health information without your authorization for the following purposes under limited circumstances:

For public health activities	• If there is a serious health or safety threat.
For health oversight	• HIV Alliance may use or disclose PHI for government health care oversight activities. • HIV Alliance may disclose information to the state and federal agencies that regulate us, such as the US Department of Health and Human Services for reasons such as audits, investigations, inspections and licenses.
For law enforcement and as required by law	• HIV Alliance will disclose PHI for law enforcement as required or allowed by federal or state law.
For disputes and lawsuits	• HIV Alliance will disclose PHI in response to a court order. • If you are involved in a lawsuit or dispute, HIV Alliance may share your information in response to legal requirements.
Other use and disclosures require your written authorization	• For other purposes, HIV Alliance will ask for your written permission before using or disclosing PHI. • You may cancel this permission at any time in writing, however, cancelling permission will not apply to any previously made permitted disclosures.
Other laws protect PHI	• Many HIV Alliance programs have other laws for the use and disclosure of health information about you. • Usually, you must give your written permission for HIV Alliance to use and disclose your HIV/AIDS, mental health and chemical dependency treatment records.

Your rights

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

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.

Rights related to your PHI

- You may make a request for your records, may request a correction to your record or request a list of disclosures in writing.
- You may be asked to cover the cost of providing records.
- In most cases your request will be met within 30 days.

Right to see and get copies of your medical records

- In most cases, you can ask to see and request to get copies of your health records.
- You must make the request in writing. We may charge a reasonable, cost based fee.
- You may not be permitted to review
  -Psychotherapy notes. The Behavioral Health Services supervising clinician will make a prompt determination on all such requests.
  -Information complied in anticipation of a civil, criminal, or administrative action.
  -Other information restricted or prohibited under the law.

Right to revoke permission

- If you are asked to sign an authorization to use or disclose PHI, 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.

How to contact HIV Alliance to use your privacy rights:

If you have questions related to our privacy practices you may contact our Privacy Officer at 541.342.5088

In the future, HIV Alliance may change its "Notice of Privacy Practices". Any changes will apply to information HIV Alliance already has and will also apply to information HIV Alliance receives in the future. A copy of the new notice will be posted at each HIV Alliance site and facility. A copy of the new notice will be provided as required by law. You may ask for a copy of the current notice anytime you visit an HIV Alliance Facility.

Notice of Privacy Practices

Acknowledgment Receipt

Please review carefully.

This Notice of Privacy Practices tells you how HIV Alliance may use or disclose information about you. Not all situations will be described. HIV Alliance is required to give you a notice of our privacy practices for the information we collect and keep about you.

I, (print your name)_____,
have been given a copy of the HIV Alliance Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

_____ _____

Client signature Date

_____ _____

Legal or personal representative of client, if applicable Relationship

Please have this document completed and signed by the individual receiving the Notice of Privacy Practices. File this copy in the client chart.

HIV ALLIANCE POLICIES AND PROCEDURES
Dept: Client Services
Subject: Termination of Services

 Effective: June 2005

Policy: Client Services has the right to terminate the case management relationship with the client in necessary situations. Termination will always be done in accordance with the Oregon State HIV Case Management Standards and OAR 333-022-2110. No termination of services shall occur without the approval of the Program Director and Client Services Director. Termination of services will only occur as a last resort and only when other possible solutions have been exhausted. Documentation of the events leading up to and surrounding the termination shall be charted in the clients file by the case manager involved and the Client Services Director.

The Oregon Administrative Rule states:
333-022-2110
Termination
(1) A client enrolled in the HIV Case Management Program may be terminated from the program for any of the following:
(a) Failure to continue to meet eligibility requirements;
(b) Placement in a custodial institution for more than 180 days, such as a state or federal prison that is legally obligated to provide medical services;
(c) Cannot be located or is unresponsive to program requests for more than 60 days;
(d) Submitting false, fraudulent or misleading information in order to obtain or retain benefits;
(e) Fraudulent use of supportive services; or
(f) Consistent documented violations of the responsibilities outlined in OAR 333-022-2070.

(2) If an agency proposes to terminate an individual from the program it must notify the individual in writing, and the individual must be informed of their hearing rights per ORS 183.415. An appeal must be submitted to the local or state authority to arrange the hearing.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

Clients who are terminated because they knowingly misuse HIV Alliance funds as described in (1)(d) and (1)(e) above may reapply for HIV Alliance services after a 60 day period. Fraudulent use of funds provided through our partner programs, for example OHOP, may result in termination.

If terminated, the client's paper chart will be closed and their CAREWare file will be closed as well. In the case of termination, client will receive no services from the Client Services Program at HIV Alliance. When services are terminated case management staff may request that the client complete tasks before they can become eligible for services again. This request is to be documented in writing.

Upon occurrence of any above-mentioned behavior, the Client Services Manager will be immediately informed and will engage in necessary investigation. In the case of termination, the client will be informed by the Client Services Manager verbally if possible and in writing in all cases. If the client is also a client of Oregon Housing & Community Services Program (OHOP), the Housing Coordinator will be informed about the conditions and cause of the termination.

Clients who are terminated have the right to file a grievance with HIV Alliance. Clients must file this grievance within 15 days of the termination. Clients will be notified of this right and provided the grievance form when they receive their notice of termination.

If the grievance process does not resolve the issue, clients have a right to a hearing as described in the Oregon Administrative Rule 333-022-2120:

Hearings
A client who has been terminated has a right to a contested case hearing in accordance with ORS chapter 183.
Stat. Auth.: ORS 413.042, 431.250, 431.830
Stats. Implemented: ORS 431.250, 431.830

Procedures:

1. Once aware of misuse or fraudulent use of funds, theft or threats, CS Staff should notify the Client Services Manager.
2. Once aware of misuse or fraudulent use of funds, theft or threats, staff should complete an HIV Alliance Incident Report Form and submit to both the Client Services Manager, Program Director and Executive Director.
3. Other staff will be notified of incident as necessary in order to ensure safety and or gather information needed to address the situation.
4. Program Director and Client Services Manager will interview staff and or client to gather information needed to address the situation.
5. Management staff will hold case conference to determine next steps.
6. In the case of termination, Program Director will notify the client of the decision verbally if possible and in writing in all cases.
7. Clients will be notified in writing of their right to file a grievance with HIV Alliance. If the grievance response does not resolve their issue clients will be notified of their right to a hearing per OAR 333-022-2120
8. Case Management and other related staff will be notified of the decision to terminate services.
9. In the case of termination, file will be removed from the active file cabinet and closed in CAREWare.
10. In the case of dual enrollment with OHOP, staff will request that client inform the Housing Coordinator of termination within 7 days. If client is unable or unwilling to do so, staff will notify HC immediately following the 7-day period.

1/24/05 Ryandel, edit 11-07, edits 8-15