



Notice of Privacy Practices

(Effective 2/16/2026)

THIS NOTICE DESCRIBES HOW INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Our Duty to You. We at the New York State Office of Mental Health (OMH) understand that the information we collect about you and your health is personal. We keep a record of the care and services you receive at this facility to provide you with quality care and to comply with certain legal requirements. We are committed to protecting your health information and are required by state and federal law to maintain the privacy of your health information. We are required to give you this notice of privacy practices that details your rights and our responsibilities with respect to the health information that OMH collects and maintains about you. We are also required to abide by the terms of this notice.

This notice describes and gives some examples of the ways that your health information is permitted to be used or released. Release of your information to third parties for purposes other than treatment, payment, or health care operations, will be made only with your written authorization, or as otherwise permitted by state or federal law. You may revoke specific authorizations to release your health information, in writing, at any time. If you revoke an authorization, we will no longer release your health information to the authorized person, except to the extent that we have already used or released that information in reliance on your original authorization. If your health information is used or released without your authorization or as permitted by state and federal law, we are required to notify you.

We reserve the right to revise this notice. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we create or receive in the future. If we revise this notice, we will post a copy of the revised notice in a clear and prominent location at physical locations and on the OMH website. If we revise this notice, we will also provide a copy of the revised notice to you upon request. A copy of the most recent notice will be provided to you each time you are admitted to an OMH facility for treatment as an inpatient or outpatient.

2. Your Health Information.

- a. Your health information includes any information that relates to your past, present, or future health condition, mental health condition, or substance use disorder (SUD), the provision of health care to you; or the past, present, or future payment for the provision of health care to you.
- b. The following types of health information are granted further protections under state and federal law.
 - i. Confidential HIV Related Information: Under New York State law, confidential Human Immunodeficiency Virus (HIV)-related information, (information concerning whether or not you have had an HIV-related test, or have HIV infection, HIV-related illness, or Acquired Immune Deficiency Syndrome (AIDS), or which could indicate that a person has been potentially exposed to HIV), can only be given to entities allowed to have it by law or allowed to have it by a release that you have signed.
 - ii. SUD Treatment Information: If you have received treatment from a federally assisted SUD treatment program, meaning the program receives assistance from the United States government, federal regulations may protect your treatment records from disclosure without your written authorization. Records, or testimony relaying the content of such records, shall not be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless we receive your written consent or a court order directing such disclosure. Records shall only be used or disclosed based on a court order after you are provided with notice and an opportunity to be heard. Any court order authorizing the use

or disclosure of these records must be accompanied by a subpoena or other similar legal mandate compelling disclosure before the record is used or disclosed.

- iii. **Mental Health Information:** Under New York State law, clinical records maintained by facilities licensed or funded by the office of mental health or the office for people with developmental disabilities cannot be used or disclosed without your consent unless another exception applies.

3. Your Health Information Rights. You have the following rights regarding health information we have about you:

- a. **Right to Inspect and Obtain Copies:** You have the right to inspect and obtain a copy of your health information that may be used to make decisions about your care. Usually, this includes medical and billing records. It does not include information that is needed for civil, criminal, or administrative actions or proceedings. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We will provide a copy or a summary of your health information, usually within 30 days of your request.

To inspect or obtain a copy of your health information that may be used to make decisions about you, you must submit your request in writing to _____.

We may deny your request to inspect and obtain a copy in very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. The Medical Records Access Review Committee will review your request and the denial. The person(s) conducting the review will not include the person who denied your request. We will comply with the outcome of the review.

- b. **Right to Amend:** If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as the information is kept by or for us.

We may deny your request if you ask to amend information that: (1) was not created by us; (2) is not part of the health information kept by us; (3) is not part of the information which you would be permitted to inspect or copy; or (4) is determined to be accurate and complete. We will inform you of a denial of your request in writing within 60 days.

To request an amendment, your request must be made in writing and submitted to _____. In addition, you must provide a reason that supports your request.

- c. **Right to an Accounting of Disclosures:** You have the right to request a list of information releases that we have made of your health information. The list will not include: health information releases: (1) made for purposes of providing treatment to you, obtaining payment for services, or releases made for other administrative or operational purposes; (2) made for national security; (3) made to correctional and other law enforcement custodial situations; (4) made based on your written authorization; (5) made to persons who are involved in your care; or (6) made prior to April 14, 2003.

To request this list or accounting of disclosures, you must submit your request in writing to _____. Your request must state a date range which may not be longer than 6 years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- d. **Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for the purpose of treatment, payment, or health care operations. You also have the right to request that we restrict or limit health information about you that we may use or disclose to someone who is involved in your care or the payment for your care, such as a family member. For example, you could ask that we not use or disclose information about the medication you are taking to your spouse or significant other.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to _____. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

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.

- e. **Right to Request Confidential Communications:** You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at a certain phone number or by mail.

To request confidential communications, you must make your request in writing to _____. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- f. **Right to a Paper Copy of this Notice:** You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
- g. You may obtain a copy of this notice at our website, https://omh.ny.gov/omhweb/hipaa/manual/appendix6_NPP.htm. To obtain a paper copy of this notice please contact _____.

4. Use and Disclosure of Your Health Information. OMH provides a wide range and variety of health care to the people of New York. For this reason, not all types of uses and releases can possibly be described in this document. We have listed some common examples of permitted uses and disclosures below.

- a. **For Treatment:** Caregivers, such as nurses, doctors, therapists and social workers, may use your health information to determine your plan of care. Individuals and programs within OMH may share health information about you to coordinate the services you may need, such as clinical examinations, therapy, nutritional services, medications, hospitalization, or transfers or referrals for follow-up care. We may use health information about you to provide you with treatment or services. If you have received treatment from a federally assisted SUD treatment program, we are required to obtain a signed written consent before any health information received from the treatment program may be used or disclosed. Once you have authorized this information to be disclosed to or by OMH, the information may then be redisclosed in accordance with the HIPAA rules. A single consent may be used to authorize uses and disclosures of federally assisted SUD treatment program information for treatment, payment and health care operations. If federally assisted SUD treatment program records contain separate counseling notes, an additional signed written consent form will be required.
- b. **For Payment:** OMH may release information about you to your health plan or health insurance carrier to obtain payment for our services. For example, we may need to give your health plan information about a clinical exam or medications that you received so your health plan will pay us for treatment or services we provided. We may also share your information, when appropriate, with other government programs such as Workers’ Compensation, Medicaid, Medicare, or Indian Health Services to determine if you are eligible for, or to coordinate, your benefits, entitlements, and payments. We may need to disclose a limited amount of information about you to explore your financial situation for possible sources of payment for your care, but we will only do so as permitted under law. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. If you are due a refund of money because you have overpaid for our services, we may share a limited amount of your information with the NYS Office of the State Comptroller to obtain that refund for you. If you have received treatment from a federally assisted SUD treatment program, we are required to obtain a signed written consent before any health information received from the treatment program may be used or disclosed. The information may be redisclosed in accordance with the HIPAA rules. A single consent may be used to authorize uses and disclosures of federally assisted SUD treatment program information for treatment, payment and health care operations. If federally assisted SUD treatment program records contain separate counseling notes, an additional signed written consent form will be required.

- c. **For Health Care Operations:** OMH may use and release information about you to ensure that the services and benefits provided to you are appropriate and are high quality. For example, we may use your information to evaluate our treatment and service programs or to evaluate the services of other providers that use government funds to provide health care services to you. We may combine health information about many individuals to research health trends, or determine what services and programs should be offered, or whether new treatments or services are useful. We may share your health information with our business partners who perform functions on our behalf. For example, our business partners may use your information to perform coordination of care or other assessment activities. OMH requires that our business partners abide by the same level of confidentiality and security as OMH when handling your information. If you have received treatment from a federally funded SUD treatment program, we are required to obtain a signed written consent before any health information received from the treatment program may be used or disclosed. The information may be redisclosed in accordance with the HIPAA rules. A single consent may be used to authorize uses and disclosures of federally assisted SUD treatment program for treatment, payment and health care operations. If federally assisted SUD treatment program records contain separate counseling notes, an additional signed written consent form will be required.
- d. **To Keep You Informed:** Unless you provide us with alternative instructions, we may contact you about reminders for treatment, medical care, or health check-ups. We may also contact you to tell you about health-related benefits or services that may be of interest to you or to give you information about your health care choices.
- e. **Facility Directories:** Some OMH facilities use patient directories. If you are receiving care from a facility that does use one, and if you do not object, we may put your name and location in our patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religious affiliation may be shared with clergy.
- f. **To Other Government Agencies Providing Benefits or Services:** We may release your health information to other government agencies that are providing you with benefits or services when the information is necessary for you to receive those benefits or services.
- g. **Research:** OMH may release your health information for research projects that have been reviewed and approved by a special approval process to ensure the continued privacy and protection of the health information. We may also disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave our facility.
- h. **As Required by Law:** We will disclose health information about you when required to do so by federal, state, or local law.
- i. **To Avert a Serious Threat to Health or Safety:** We may release your health information if it is necessary to prevent a serious threat to your health or safety or to the health and safety of the public or another person.
- j. **Public Health Activities:** We may disclose health information about you to public health agencies, including de-identified health information received from a federal funded SUD treatment program, subject to applicable provisions of state and federal law, for the following kinds of activities:

 - i. To prevent or control disease, injury or disability;
 - ii. To report births and deaths;
 - iii. To report child abuse or neglect to agencies authorized by law to receive these reports;
 - iv. To report reactions to medications or problems with products to the Food and Drug Administration (FDA);
 - v. To notify people of recalls of products they may be using;
 - vi. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading the disease or condition; and
 - vii. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence (such disclosure will only occur if you agree or when required or authorized by law).

- k. Health Oversight Activities:** OMH may share your health information within OMH and with other agencies for oversight activities authorized by law. Examples of these oversight activities include audits, inspections, investigations, and licensure.
- l. Judicial and Administrative Proceedings:** If you are involved in a lawsuit or dispute, we may release health information about you in response to a court or administrative order. We may also release health information about you in response to a court order, subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information required. Special rules may apply to the disclosure of SUD information obtained from federally-assisted SUD treatment programs in judicial proceedings.
- m. Law Enforcement:** We may release health information to a law enforcement official:
 - i.** In response to a court order, subpoena, warrant, summons, or other similar process;
 - ii.** To identify or locate a suspect, fugitive, material witness, or missing person;
 - iii.** About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
 - iv.** About a death we believe may be the result of criminal conduct;
 - v.** About criminal conduct at the hospital; or
 - vi.** In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime;
- n. Coroners, Medical Examiners and Funeral Directors:** We may release health information to a coroner or medical examiner to carry out their duties as authorized by law (for example, to identify a deceased person or determine the cause of death). We may also release health information to funeral directors as necessary to carry out their duties.
- o. Organ Donation:** If you are an organ donor, we may release your health information to an organization that procures, banks, or transports organs for the purpose of an organ, eye, or tissue donation or transplantation.
- p. National Security and Protection of the President:** We may release your health information to an authorized federal official or other authorized persons for purposes of national security, for providing protection to the President, or to conduct special investigations, as authorized by law.
- q. Inmates/Forensic Patients:** If you are an inmate of a correctional institution, or a person who is receiving care in a psychiatric hospital as a result of a criminal court order or are under the custody of a law enforcement official (that is, a forensic patient), we may release health information about you to the correctional institution or law enforcement official. The information released must be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution or psychiatric hospital.
- r. To the Military:** If you are a veteran or a current member of the armed forces, we may release your health information as required by military command or Veterans Administration authorities.
- s. If you do not object and the situation is not an emergency and disclosure is not otherwise prohibited by stricter laws, we are permitted to release your health information under the following circumstances:**
 - i. To Individuals Involved in Your Care:** We may release your health information to a family member, other relative, friend, or other person who you have identified to be involved in your health care or the payment of your health care.
 - ii. To Family:** We may use your health information to notify a family member, a personal representative or a person responsible for your care, of your location, general condition, or death.
 - iii. To Disaster Relief Agencies:** We may release your health information to an agency authorized by law to assist in disaster relief efforts.

- 5.** Report a Problem. If you believe your privacy rights have been violated, you may file a complaint with any or all the agencies listed below. There will be no penalty or retaliation for filing a complaint:

1. New York State Office of Mental Health

Facility Name: _____

Contact Name: _____

Contact Title: _____

Facility Address: _____

Contact Phone Number: _____

Contact Email Address: _____

2. Department of Health and Human Services

Office of Civil Rights

200 Independence Avenue, S.W. Washington, D.C. 20201

1-877-696-6775

<https://www.hhs.gov/hipaa/filing-a-complaint/index.html>

- 6.** To obtain more information about OMH's privacy practices, to receive additional copies of this notice, or to receive request forms to access or amend your health information, please contact:

Facility Name: _____

Contact Name: _____

Contact Title: _____

Facility Address: _____

Contact Phone Number: _____

Contact Email Address: _____

- 7.** For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Patient Name:	Medical Record Number:
Facility/Site/Program Name:	

By signing this form I or my Personal Representative acknowledge and agree that I have received a copy of the OMH Notice of Privacy Practices.

Signature of Patient or Personal Representative: _____ Date: _____

Patient Name (Printed): _____

If not the patient, name of Personal Representative (Printed): _____

Authority of Personal Representative to sign on behalf of patient: _____

STAFF USE ONLY

If the individual has a personal representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the personal representative. If the individual or personal representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the good faith efforts made to obtain it.

Date the Notice of Privacy Practices given to the individual or personal representative: _____

Method of Delivery: ☐ In-Person Meeting ☐ Mailing ☐ Electronic ☐ Other _____

Reason Individual or personal representative did not sign this form:

☐ Individual or personal representative chose not to sign.

☐ Individual or personal representative did not respond after more than one attempt.

☐ Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than one attempt must have been made.

Staff Signature: _____ Title: _____

Print Name: _____ Date: _____