AUTISM SERVICES INC.

Notice of Privacy Practices in OPWDD Programs

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.

Autism Services Inc. uses your Protected Health Information for your treatment, to obtain payment for our services and for our operational purposes, such as improving the quality of care we provide to you. We are committed to maintaining your confidentiality and protecting your health information. We are required by law to provide you with this Notice, which describes our health information privacy and those of affiliated health care Autism Services Inc.

This Notice applies to all information and records related to your care that our Autism Services Inc. workforce members and Business Associates have received or created. It also applies to health care professionals, such as physicians, and organizations that provide care to you from the various Autism Services Inc. Departments. It informs you about the possible uses and disclosures of your Protected Health Information and describes your rights and our obligations regarding your Protected Health Information.

We are required by law to:

- Maintain the privacy of your Protected Health Information;
- Provide to you this detailed Notice of our legal duties and privacy practices relating to your Protected Heath Information; and
- Abide by the terms of the Notice that are currently in effect. We reserve the right to change the terms of this Notice, and will notify you or your personal representative if we make any material changes to the Notice.

I. WITH YOUR CONSENT, WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We are required by New York State Law to obtain a signed Consent allowing us to use and disclose your Protected Health Information or Private Information (collectively referred to as "Protected Health Information") to others to provide you with treatment, obtain payment for our services, and run our health care operations. Here are examples of how we may use and disclose your health care information.

FOR TREATMENT: Our staff and affiliated health care professionals may review and record information in your record about your treatment and care. We will use and disclose this health information to health care professionals in order to treat and care for you. For example, a

physician may consult with another physician located at another location to determine how to best diagnose and treat you.

FOR PAYMENT: Autism Services Inc. may use and disclose your Protected Health Information to others in order for Autism Services Inc. to bill for your health care services and receive payment. For example, we may include your health information in our claim to Blue Cross/Blue Shield or Medicare in order to receive payment for services provided to you. We may also disclose your health information to other health care provider agencies so that they can receive payment for their services.

FOR HEALTH CARE OPERATIONS: We may use and disclose your Protected Health Information to others for Autism Services Inc.'s business operations. For example, we may use Protected Health Information to evaluate Autism Services Inc.'s services, including the performance of our staff, and to educate our staff.

II. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR OTHER SPECIFIC PURPOSES

BUSINESS ASSOCIATES: We may share your Protected Health Information with our vendors and agents who create, receive, maintain or transmit PHI for certain functions or activities on behalf of Autism Services Inc.. These are called our "Business Associates". To protect and safeguard your health information, we require our Business Associates and subcontractors to appropriately safeguard your information.

FAMILY AND FRIENDS INVOLVED IN YOUR CARE: Unless you object, we may disclose your Protected Health Information to a family member or close personal friend, including clergy, who is involved in your care or payment for that care.

PERSONAL REPRESENTATIVE: If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative or to your next of kin, as permitted under state and federal law.

DISASTER RELIEF: We may disclose your Protected Health Information to an organization assisting in a disaster relief effort.

PUBLIC HEALTH ACTIVITIES: We may disclose your Protected Health Information for public health activities including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may also disclose your information to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition if a law permits us to do so.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your Protected Health Information to health oversight agencies authorized by law to conduct audits, investigations, inspections and

licensure actions or other legal proceedings. These agencies provide oversight for the Medicare and Medicaid programs, among others.

REPORTING VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: If we have reason to believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your Protected Health Information to notify a government authority if required or authorized by law, or if you agree to the report.

LAW ENFORCEMENT: We may disclose your Protected Health Information for certain law enforcement purposes or other specialized governmental functions.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose your Protected Health Information in the course of certain judicial or administrative proceedings.

RESEARCH: We will request that you sign a written authorization before using your Protected Health Information or disclosing it to others for research purposes.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, ORGAN PROCUREMENT ORGANIZATIONS: We may release your Protected Health Information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. However, any disclosure would be made only to someone able to help prevent the threat.

MILITARY AND VETERANS: If you are, or were, a member of the armed forces, we may use and disclose your Protected Health Information as required by military command authorities. We may also use and disclose Protected Health Information about foreign military personnel as required by the appropriate foreign military authority.

WORKERS' COMPENSATION: We may use or disclose your Protected Health Information to comply with laws relating to worker's compensation or similar programs.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES; PROTECTIVE SERVICES: We may disclose Protected Health Information to authorized federal officials who are conducting national security and intelligence activities or as needed to provide protection to the President of the United States, or other important officials.

AS REQUIRED BY LAW: We will disclose your Protected Health Information when required by law to do so.

III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF YOUR PROTECTED HEALTH INFORMATION

We will use and disclose your Protected Health Information other than as described in this Notice or required by law only with your written authorization. You may revoke your authorization to use or disclose Protected Health Information in writing, at any time. To revoke your authorization, contact the appropriate Autism Services Inc. Staff. If you revoke your authorization, then we will no longer use or disclose your Protected Health Information for the purposes covered by the authorization, except where we have already relied on the authorization.

Fundraising.

Autism Services Inc. may contact you or your personal representative to raise money for the Autism Services Inc.. We may also share your demographic information with a charitable foundation that may contact you or your personal representative to raise money on our behalf. In certain circumstances, you must provide us with your written authorization for our use of your information for fundraising and you also have the opportunity to opt out or restrict your receiving future fundraising communications. Your request to opt out of receiving future fundraising communication will revoke any prior authorizations and you will not receive any future communications.

Marketing.

In most circumstances, Autism Services Inc. is required by law to receive your written authorization before we use or disclose your health information for marketing purposes. Under no circumstances will we sell our individual lists or your health information to a third party without your written authorization.

Psychotherapy Notes.

In most circumstances, Autism Services Inc. is required by law to obtain your written authorization before we use or disclose psychotherapy notes.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your health information. If you wish to exercise any of these rights, you should make your request to the appropriate Autism Services Inc. Staff.

RIGHT OF ACCESS TO PROTECTED HEALTH INFORMATION: You have the right to request, either orally or in writing to inspect and obtain a copy of your Protected Health Information, subject to some limited exceptions. If available, you have the right to access your information in electronic format. We must allow you to inspect your records within 10 days of your request. If you request copies of the records, we must furnish you a copy within 30 days of that request if the records are maintained on site and within 60 days if maintained off site. We may charge a reasonable fee for our costs in copying and mailing your requested information or provision of information in electronic format.

In certain limited circumstances, we may deny your request to inspect or receive copies. If we deny access to your Protected Health Information, we will provide you with a summary of the information, and you have a right to request review of the denial. We will provide you with information on how to request a review of our denial and how to file a complaint with us or the Secretary of the Department of Health and Human Services.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on the way we use and disclose your Protected Health Information for our treatment, payment or health care operations. You also have the right to request restrictions on our disclosures of your Protected Health Information to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction, and in some cases, the law may not permit us to accept your restriction. However, if we do agree to accept your restriction then we will comply with your restriction EXCEPT IF: (1) you are being transferred to another health care institution; (2) the release of records is required by law, or (3) the release of information is needed to provide you emergency treatment. If your restriction applies to disclosure of information to a health plan for payment or health care operations purposes and is not otherwise required by law, and where you paid out of pocket, in full, for items or services, we are required to honor that request.

RIGHT TO RECEIVE NOTICE OF A BREACH: We will notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. A "Breach" means the unauthorized access, acquisition, use, or disclosure of Protected Health Information which compromises the security or privacy of Protected Health Information, except: (1) an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information; (2) any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of a covered entity or business associate (a) was made in good faith and within the course and scope of the employment or other professional relationship of such employee, or individual, respectively, with the covered entity or business associate; and (b) such information is not further acquired, accessed, or used or disclosed by any person; or (3) any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by a covered entity or business assosciate to another similarly situated individual at the same facility provided that any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization. Autism Services Inc. must notify you of any breach unless we can demonstrate, based on a risk assessment, that there is a low probability that the PHI has been compromised.

"Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of action we are taking to investigate the breach, mitigate losses, and protect against further breaches; and
- contact information, including a toll-free number, e-mail address, Website or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more residents whose contact information is out of date, we will post a notice of the breach on the home page of our web site or in a major print or broadcast media. If the breach involves more than 500 residents in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 residents, we are required to immediately notify the Secretary of Health and Human Services. We are also required to submit an annual report to the Secretary of a breach that involved less than 500 residents during the year and will maintain a written log of breaches involving less than 500 residents. Notification to the Secretary will occur within 60 days of the end of the calendar year in which the breach was discovered.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request an "accounting" of our disclosures of your Protected Health Information. This is a listing of certain disclosures of your Protected Health Information made by Autism Services Inc. or by others on our behalf, but does not include disclosures made for treatment, payment and health care operations or certain other purposes unless the records are maintained in an Electronic Health Record. Records maintained in an Electronic Health Record will include disclosures made for treatment, payment, health care operations and other purposes.

You must submit a request in writing, stating a time period beginning after April 13, 2003 that is within six years from the date of your request. Where an Electronic Health Record is used, we will provide you with an accounting of disclosures for a 3 year period. You are entitled to one free accounting within one 12-month period. For additional requests, we may charge you our costs.

We will usually respond to your request within 60 days. Occasionally, we may need additional time to prepare the accounting. If so, we will notify you of our delay, the reason for the delay, and the date when you can expect the accounting.

RIGHT TO REQUEST AMENDMENT: If you think that your Protected Health Information is not accurate or complete, then you have the right to request that Autism Services Inc. amend such information for as long as the information is kept in our records. Your request must be in writing and state the reason for the requested amendment. We will usually respond within 60 days, but will notify you within 60 days if we need additional time to respond, the reason for the delay and when you can expect our response. We may deny your request for amendment, and if

we do so, we will give you a written denial including the reasons for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

RIGHT TO A PAPER COPY OF THIS NOTICE: It is Autism Services Inc. policy to provide you with a paper copy of this notice.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location. For example, you can request that we speak to you only at certain private locations. We will accommodate your reasonable requests.

V. COMPLAINTS

If you believe that your privacy rights have been violated, then you may file a complaint in writing with Autism Services Inc. or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with Autism Services Inc., contact:

Autism Services Privacy Officer
4444 Bryant Stratton Way
Williamsville, New York 14221
(716) 631-5777

No one will retaliate or take action against you for filing a complaint.

VI. CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all Protected Health Information already received and maintained by Autism Services Inc. as well as for all Protected Health Information we receive in the future. We will post a copy of the current Notice in the appropriate Autism Services Inc. Department. In addition, we will provide a copy of the revised Notice to all individuals/consumers.

If you have any questions about this Notice or would like further information concerning your privacy rights, then please contact:

Autism Services Privacy Officer
4444 Bryant Stratton Way
Williamsville, New York 14221
(716) 631-5777

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AUTISM SERVICES INC.

INDIVIDUAL'S WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Participant Name: _____

I acknowledge that I have received a copy of Autism Services Inc.'s Notice of Privacy Practices and have been advised of how Autism Services Inc. will handle my Protected Health Information. I have also been advised of my rights to obtain access to and control my Protected Health Information. I understand that I may receive other notices which describe how Autism Services Inc. will handle specialized forms of Protected Health Information such as HIV/AIDS-related, alcohol and drug abuse, and genetic information and psychotherapy notes.

SIGNATURE

I have received a copy of Autism Services Inc.'s Notice of Privacy Practices. I have had an opportunity to ask questions about the Notice and the use or disclosure of my Protected Health Information.

Signature of Individual or Personal Representative:_____

Print Name of Individual or Personal Representative:_____

Description of Individual Representative's Authority:_____

Date:_____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address:_____

_____

_____

Telephone: _____ (Daytime) _____ (Evening)

For Autism Services Inc. Use Only

Date Notice Provided _____

Name of Staff Member_____Title_____