Notice of Privacy Practices
Northern Cass D.A.C.
D.A.C. – Bemidji

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

If you have any questions regarding this notice, then please contact Northern Cass D.A.C. Privacy Officer, Jody Weber, at 218.547.1121 or D.A.C. – Bemidji Privacy Officer, Jane Boutwell, at 218.759.0052.

Protected Health Information about you that may identify you and that related to your past and present or future physical or mental health/condition, your treatment, or payment for your services. We are required by law to maintain the privacy of your Protected Health Information and to provide you with this Notice of Privacy Practices and our responsibility to you.

Uses and Disclosures of Protected Health Information (How your medical information may be used or disclosed):
We are permitted to use and disclose your Protected Health Information for services and treatment in order to provide Day Training and Habilitation services to you. We may also use your Protected Health Information for payment of these services.

Services:
We will use and disclose your Protected Health Information to provide you with Day Training and Habilitation services. We may disclose medical information to doctors, nurses, and our direct care staff. We will use your medical information to coordinate and manage your Day Training and Habilitation services with other outside departments such as the pharmacy, Department of Human Services, etc. that are involved with your Day Training and Habilitation services.

Acknowledgment of Notice of Privacy Practices
Northern Cass D.A.C.
D.A.C. – Bemidji

Client Name: _____

Client's Social Security Number: ____ - __-____

I acknowledge that I have received a written copy of the Northern Cass D.A.C./D.A.C. – Bemidji "Notice of Privacy Practices." I also acknowledge that I have been allowed to ask questions concerning this Notice and my rights under this Notice. I understand that this form will be a part of my record until such time as I may choose to revoke this acknowledgment. If I am not the client, I represent that I am authorized by law to act on the client's behalf.

_____ _____
Date **Client/Authorized Legal Representative Signature**

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o be completed Northern Cass D.A.C./D.A.C. – Bemidji if acknowledgment cannot be obtained.

Good faith efforts to obtain Acknowledgment from the client or the client's authorized representative:

____ Client/Authorized representative refused request to sign Acknowledgment.

____ Other (please describe): _____
_____
_____

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_____ _____
Date **Northern Cass D.A.C./D.A.C. – Bemidji Privacy Officer Signature**

Notice of Privacy Practices
Request for Confidential Communications
and/or
Restrictions on Uses & Disclosures
Northern Cass D.A.C.
D.A.C. – Bemidji

In accordance with Northern Cass D.A.C./D.A.C. – Bemidji Notice of Privacy Practices, I herein request that the following alternative means of communication and/or request that the uses and disclosures of my Protected Health Information be restricted in the following manner:

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Date Printed Name of Client/Authorized Legal Representative

_____
Client/Authorized Legal Representative Signature

Please indicate preferred channel of communication:

____ Verbal – Telephone Number(s)
_____

____ Written – Mailing Address(es)
_____

Please return this form to:

Northern Cass D.A.C.
Jody Weber
Privacy Officer
P.O. Box 1329
Walker, MN

D.A.C. – Bemidji
Jane Boutwell
Privacy Officer
P.O. Box 842
Bemidji, MN 56601

Confidential Information Authorization

Northern Cass D.A.C.
D.A.C. – Bemidji

I hereby grant permission to Northern Cass D.A.C./D.A.C. – Bemidji to obtain any medical, psychological, vocational, school and/or other information regarding (please print client name) _____ to be used by Northern Cass D.A.C./D.A.C. – Bemidji for programming purposes.

_____ _____

Date **Client/Authorized Legal Representative Signature**