Montana Department of Public Health and Human Services

NOTICE OF PRIVACY PRACTICES
(NOTICE OF USE OF PROTECTED HEALTH INFORMATION)

Effective Date September 23, 2013
Updated September 2, 2025

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.

The Montana Department of Public Health and Human Services (DPHHS), through its many government programs, provides services and money to individuals, and operates facilities. In the normal course of business, DPHHS may receive **protected health information (PHI)** about you. We are required by state and federal law to protect your private health information from being improperly used or released. This notice will tell you what DPHHS is legally permitted to do with your PHI, and what rights you have with regard to such information.

RELEASE AND HANDLING OF INFORMATION

When DPHHS receives PHI about you, we follow the law to protect the privacy of your information. The law permits us to use this information and share it with others if the PHI is being used for your medical **Treatment**, the **Payment** of your medical bills, or for health care **Operations**. Examples of this include:

- To hospitals and medical professionals for your treatment; or
- To insurance companies and health care providers about paying claims; and/or
- To doctors about Medicaid eligibility as part of health care operations.

DPHHS adheres to laws that provide specific instances when medical information **must** be shared, even without your written authorization. We always report: birth, death, and immunization information; contagious diseases; reactions and problems with medicines; to the police when required by law or when the courts so order; to the government for audits and reviews of our programs; to a provider or insurance company to verify your enrollment in one of our programs; to Workers' Compensation for work-related injuries and illnesses; and to the federal government if required to investigate any matter pertaining to the protection and safety of our country, the president, or government workers.

As required by law, we only share the minimum necessary PHI that is needed by the provider or agency to accomplish the authorized purpose. We do not use PHI for marketing and/or fundraising activities, nor do we sell PHI to any individual or organization.

YOUR RIGHTS

1. You are entitled to see your PHI. This right may be limited in rare and specific cases, including some psychotherapy notes (based on professional judgment), or cases where access to the information could endanger the life or safety of you or someone else (based on professional judgment).

   Most of the time you can receive a paper copy of your PHI, if requested. (In some cases, you may be charged a small fee for the copying costs). You may also receive your PHI in an electronic format, if requested and the provider or agency has the PHI available in that format.

2. If you think some of the information is wrong, you may request in writing that it be changed or that new information be added. You may request that the changes be sent to others who have received your PHI. You can request and receive a list showing where your PHI has been sent, unless it was sent as part of your provider's care.

3. You may request that your PHI be sent to another location or to a third party (such as an individual or another health care provider). You will be asked to sign a separate form, the "Authorization for the Use and Disclosure of Health Information" (HPS-402). The authorization is good for six months or until the date you put on the form (not more than 30 months). You can cancel or limit the amount of PHI sent at any time, by written notification.

   Note: If you are under the age of 18, your parents or guardians will receive your PHI, unless, by law, you are able to consent for your own health care. If you are, then your PHI will not be shared with your parents unless you sign an authorization form.

4. You have the right to request that DPHHS limit the use and sharing of information about you. DPHHS will comply with such requests as much as possible, but is not required to agree to a requested restriction. If you paid for health care services out-of-pocket, in full, you may request that your PHI not be released to your health plan.

5. If PHI is improperly disclosed and the incident is deemed a breach, by accident or for any other reason, you will be notified of the improper disclosure, including who received the PHI in error, a description of the PHI, and the steps DPHHS is taking to mitigate the disclosure and prevent future improper disclosures.

This notice is yours to keep. DPHHS will follow the requirements in this notice, and reserves the right to change this notice. If the information changes, you will be provided a copy of the updated notice. If you have questions concerning this notice, please ask the individual who gave it to you. If that individual cannot answer your questions, contact the DPHHS Privacy Officer at (406) 444-3026.

TO CONTACT DPHHS OR TO FILE A COMPLAINT

For further information about DPHHS privacy practices, to exercise your rights described in this notice, if you feel your privacy rights have been violated by DPHHS, or to file a complaint, you may contact:

DPHHS Privacy Officer
Montana DPHHS
P.O. Box 4210
Helena, MT 59604

Phone: (406) 444-3026; Website: https://dphhs.mt.gov/HIPAA

You may also file a complaint with the Secretary of Health and Human Services' Office for Civil Rights (within 180 days of the violation or the date you learned of it):

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Phone: (866) 627-7748; Email to OCRComplaint@hhs.gov; Website: http://www.hhs.gov/ocr

No one may retaliate against you, and your program benefits will not be affected, for filing a complaint or for exercising your rights as described in this notice.

By signing, I acknowledge that I have received a copy of this notice.

Signature _____ Date _____