The Growth Academy
Another Program of the Circle of Care Center for Families

**Office Use Only**

Data Entry
Date Received: _____
Date Entered: _____
Entered By: _____

Account
Payment Amount: _____
Payment Date: _____
Receipt #: _____

# 2021-2022 Membership Form

***A COPY OF A BIRTH CERTIFICATE is needed for all 6 year olds as a means to verify age.**

**Name** | **Age** | **Birthday** | **Gender** MALE: ☐ FEMALE: ☐

**Address:** | **City:** | **State** | **Zip**

**Home Phone:** | **Emergency Phone:** | **Cell Phone:**

**Ethnicity: (Circle One)** | **Lives With: (Circle One)** | **# Family Members in Household**

**Academy Member before?** Yes ☐ No ☐ | **# of years?** | **Name of School:** | **Grade:**

**Please Indicate any Medical Problems/Allergies:** | **Is the child currently taking any medications? If yes, please list:**

**Do you have Health/Medical Insurance?:** Yes ☐ No ☐ | **Insurance Provider Name:**

**Do you receive Free/Reduced Lunch?** YES ☐ NO ☐ **Do you live in a Public Housing Property?** YES ☐ NO ☐

## Parent/Guardian Contact Information:

**Father's Name:** | **Father's Employer:** | **Father's Work Phone #:**

**Mother's Name** | **Mother's Employer:** | **Mother's Work Phone #:**

**Guardian's Name** | **Guardian's Employer:** | **Guardian's Work Phone:**

One Per Child

The Growth Academy

Child's Name: _____

## Authorized Pick-up List

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## Emergency Contact

| | |
|---|---|
| **Name** | |
| **Address** | |
| **City/State/Zip** | |
| **Home #** | |
| **Work #** | |
| **Cell#** | |

One Per Child

Growth Academy Registration
Requirements, Activity and Emergency Consent

The Growth Academy program focuses on youth development. Students are required to function on a developmental level that enables them to work independently on directed activities. The main goal of the Growth Academy program is to prepare youth for every grade level in order to succeed in school and in life. Growth Academy may also require that the children be able to walk (or in the case of wheelchair bound, roll) long distances, help plan and carry out volunteer activities, and participate in activities offered in the community. I understand the requirements of the Growth Academy program and agree that my child is able to meet those requirements.

Please initial each box, indicating permission by you for your child to participate.

**I hereby grant permission for my child(ren) to**:

_____ Use all play equipment and participate in all of the activities of the program.
_____ Leave the program premises under proper supervision for neighborhood walks, field trips, or recreation/learning opportunities. in an authorized vehicle.
_____ Be included in evaluations with the program.
_____ Participate in swimming and water-related activities.

**MEDICAL:**

_____ I hereby grant permission for the Growth Academy to take whatever steps that may be necessary to obtain emergency medical care for my child if warranted.
These steps may include, but are not limited to, the following:

- Attempt to contact the parent or guardian.
- Attempt to contact the child's physician.
- Attempt to contact the parent or guardian through any of the persons listed on the emergency card filled out by the parent/guardian.
- I understand that any expense incurred in the above mentioned situations will be borne by the child's family.

**Child(ren)'s Name(s) and list any known allergies:**

_____ Age: _____

_____ _____

_____ _____

_____ _____

Parent/Guardian's Name_____

Parent/Guardian's Signature _____Date_____

One Per Parent/Guardian

I, _____, as parent/guardian of the child in which this membership application is being
(Name of Parent/Guardian)
completed for, hereby give my child permission to join the Growth Academy as a member. I also give my child permission to participate in all programs offered at and sponsored by the Growth Academy including programs and activities that will take place away from the immediate Growth Academy facilities. I understand that the Growth Academy has an "open door" policy, which means children are free to leave the Growth Academy at any time. I agree that the Growth Academy/Circle of Care will not be responsible for the welfare of my child once he/she leaves the Growth Academy premises. I, individually and on behalf of my child, agree to hold harmless, protect, indemnify, release and discharge the Growth Academy/Circle of Care and the Alabama Department of Human Resources from all claims, demands, actions, causes of action, damages or liability associated with all Growth Academy/Circle of Care activities, and I, individually and on behalf of my child, agree not to sue, make a claim against or prosecute the Growth Academy/Circle of Care or the Alabama Department of Human Resources in any fashion as a result of injury to me or to my child (or the consequences of any injury to me or to my child). I further acknowledge and agree, individually and on behalf of my child, that the terms of this release apply whether any act or omission to act which results in injury or death to me or my child occurred as a result of the conduct on the part of the Growth Academy/Circle of Care and/or the Alabama Department of Human Resources, the conduct of a third party, my conduct or the conduct of my child. I, individually and on behalf of my child, expressly waive any claim for injury or damages which I and/or my child may have against the Growth Academy/Circle of Care and/or the Alabama Department of Human Resources, whether because of negligence or otherwise, which arises by reason of any Growth Academy activities organized by the Growth Academy or by reason of any act or omission to act on the part of any employee of the Growth Academy/Circle of Care.

As the parent/guardian, I agree that the Growth Academy/Circle of Care will not be responsible for any accident to my child while on the Growth Academy/Circle of Care premises or while engaged in any of its activities away from the Growth Academy/Circle of Care. Should my child suffer from an injury or illness while in the care of the Growth Academy/Circle of Care and the Academy personnel is unable to contact me/us immediately, it shall be authorized to secure such emergency medical attention, services and care for the child as may be deemed necessary by Academy personnel. I/we shall assume full responsibility for payment for any such attention, care and services. I hereby release, indemnify and hold harmless the Growth Academy/Circle of Care, the Alabama Department of Human Resources as well as any officer, director, employee, or agent of the Academy from any liability, claim or demand resulting from any legal medical attention and assistance that may be needed and provided as a result of an injury or harmful incident to my child at the time of entering my child in the Growth Academy program.

I understand that my child must meet the behavioral expectations as stated under the Code of Conduct Section of this application. I also understand that violations of the stated behavioral code, including rules and regulations not mentioned on this membership application, can result in suspension or expulsion of my child from the Growth Academy.

I also understand that the Academy is not, nor claims to be, a licensed Day Care Center.

***I/we agree to keep the Growth Academy informed of changes in telephone numbers, etc. where I/we can be reached.**
***Once my child's Membership Application is processed, I understand that membership fees are nonrefundable**.

**Parent/Guardian Signature:** _____ **Date:** _____

**Authorization To Release School Records**

I, _____, as parent/guardian of _____
(Name of Parent/Guardian) (Name of Child)

Hereby authorize the Chambers County School District to release school records of my child limited to **Grades, Test Scores, copies of Report Cards/Progress Reports and Attendance Information to include School Suspension** only to the authorized individuals of The Growth Academy & the Circle of Care. It is understood that The Growth Academy & the Circle of Care or any of its representatives will not release this information to a third party. Furthermore, it is understood that once obtained, this information will be kept in strict confidence and will be used only to assess academic strengths and weaknesses in order to provide assistance where needed at the Growth Academy, as well as to evaluate program effectiveness. I waive any rights to privacy under the Family Education Rights to Privacy Act of 1974 (FERPA) and release the Chambers County School District from any FERPA obligations in the release of the educational records.

This authorization to release my child's educational records shall be valid for a period of one year from the date hereof and shall automatically expire after one year unless the undersigned notifies the Chambers County School District in writing of the renewal of the authorization.

**Parent/Guardian Signature:** _____ **Date:** _____

One Per Child

# The Growth Academy

## CODE OF CONDUCT

**As a member of the Growth Academy ("The Academy"), I promise to:**

- **Play fair and be honest**
- **Be respectful to Academy staff**
- **Say good things about others**
- **Use appropriate language**
- **Dress and wear my clothes appropriately**
- **Listen when staff are talking during programs**
- **Sign-in each day when I arrive at the Academy**
- **Be respectful to other members and their property**
- **Take care of the Academy facility and equipment**
- **Resolve disagreements in a positive way**
- **Always keep my hands to myself**
- **Inform the staff if I have a problem**

**Signature of Child:** _____

(Signature indicates that the Code of Conduct has been read and is completely understood)

One Per Child

# OUTCOME MEASUREMENT/SURVEY CONSENT FORM

I, _____, give my permission for the Growth Academy
(Parent/Guardian)

& Chambers County Schools to survey and interview my child(ren) to find out what his/her behaviors, skills and attitudes are in regards to issues such as health risks and habits, positive self-esteem, respect for diversity, education and educational resources, positive relationships, career choices, and connection to community, as well as his/her experiences at the Academy. I understand that the purpose of these surveys and interviews is to help find out how well the Academy is meeting my child(ren)'s needs and to identify areas which may call for further attention. I also understand that this information will remain private, and that only the management staff and assigned research assistants at the Growth Academy/Circle of Care will be able to look at his/her responses.

I understand that my child(ren)'s responses will be automatically grouped together with the responses of other Growth Academy members for any public presentation of the findings, and that my child(ren) will never be individually linked to his/her responses. In addition, I understand that I can take back my permission at any time, and that my permission automatically stops at the end of this one-year membership period. Finally, I understand that I can receive a copy of this signed Consent Form, and that upon written request I may arrange to discuss the findings with the Executive and/or Program Director at the Circle of Care/Growth Academy.

**Child(ren)'s Name(s):**

_____

_____

_____

_____

**Parent/Guardian Signature:** _____ **Date:** _____

One Per Parent/Guardian

Circle of Care Center for Families' Growth Academy
3300 23rd Drive
Valley, AL 36854
(334) 768-4091 Circle of Care Office
(334) 497-2392 Growth Academy Office

# Release Form

Date_____

I give permission to the Growth Academy/Circle of Care, for the release of copies of:

A. Immunization Record

B. Birth Certificate

C. Test scores, including standardized and state

D. Grades

E. Attendance Record

F. Behavior Record

from the school record regarding my child(ren) for the benefit of records kept at the Circle of Care/Growth Academy. I give permission for the Growth Academy staff to discuss any educational needs with those institutions for my child when necessary.

**Child(ren)'s Name(s):**

_____

_____

_____

_____

Parent/Guardian:_____

Witness:_____

# The Growth Academy

## Parent/Guardian Notice & Consent Form

Growth Academy members will be participating in various curricula aimed at academic and social success. These curricula will be evidence based and provided in coordination as well as collaboration with Chambers County Schools. They will cover a breadth of topics including but not limited to math, reading, history, science, technology, engineering as well as educating members about alcohol, tobacco, other drugs, teen sexual involvement and HIV/AIDS. Please keep in mind that our programs do the following:

- Only discusses topics that are relevant to your child's stage of development. For example, we will not discuss the risks of early sexual involvement with 7-year-olds.
- Only teaches the facts about alcohol, tobacco and other drugs and the risks of teen sexual involvement and HIV/AIDS. We do not discuss our personal theories or beliefs.
- Teaches kids how to avoid negative peer pressure (refusal skills training).
- Does not advocate birth control or talk about abortion.

In addition, because of grant funding requirements, it may be necessary that we administer pre- and post-tests, an anonymous questionnaire about a child's personal background, and, in some cases, keep progress notes on participants.

It may also be necessary that the Growth Academy survey participants about their Academy/school experience and behaviors, skills and attitudes.

These curricula are a requirement of participation in the Growth Academy.

☐ I hereby give permission for my child(ren) to participate in the Growth Academy program.

**Child(ren)'s Name(s):**

_____ Age: _____

_____ _____

_____ _____

_____ _____

**NOTE: It is vital that your child return this letter in order to participate in the program.**

**Parent/Guardian Signature:** _____ **Date:** _____

One Per Parent/Guardian

# Photo/Video
# Release Agreement

**Chambers County, Alabama**
**School/Organization Name: Growth Academy**

1. I, the undersigned, consent and agree that still photographs, motion pictures, or television presentations in the form of either live or video tape may be made of myself, my child(ren) by the Circle of Care/ Growth Academy

2. This release gives the the Circle of Care/Growth Academy the right to use the above-listed visual material in conjunction with the teaching, instruction, training, information and education of employees of the organization or the general public.

3. Further, I hereby release the the Circle of Care/Growth Academy and forever discharge any claim of any nature against them as long as the material is used in compliance with the above-stated paragraph 2.

☐ I HEREBY GRANT this consent as (parent-guardian) a voluntary contribution in the interest of the said reasons listed in paragraph 2.

☐ I DO NOT GRANT this consent as (parent-guardian) a voluntary contribution in the interest of the said reasons listed in paragraph 2.

Name: _____

Address: _____

_____

Telephone: _____

Photo Description: Participation in the Circle of Care/Growth Academy after-school/summer program activities.

Children Participating in Program:

Name: _____

_____

_____

_____

Signature: _____ Date: _____

Photographer, producer or witness: _____

One Per Parent/Guardian

Dear Internet Users:

The Growth Academy Acceptable Use Policy is designed to provide guidelines for using the Internet in the classrooms. Media center, labs, offices, and all areas included in the Growth Academy center. Please take time to read this policy. If you have any questions, contact Kim Dozier at (334) 497-2392.

For students, this policy must be read and signed by both guardian and student.

Please note that if you violate the terms of this policy, you may lose privileges or receive punishment as defined in the applicable handbook. It is your responsibility to read and ask questions about this policy.

I acknowledge that I have read, understand, and agree to all terms as outlined in the Internet Acceptable Use Policy. I further understand that this agreement will be kept on file for future reference.

| | |
|---|---|
| Name of User 1 (Printed) | Signature of User 1 |
| Name of User 2 (Printed) | Signature of User 2 |
| Name of User 3 (Printed) | Signature of User 3 |
| Name of User 4 (Printed) | Signature of User 4 |
| Name of Parent/Guardia (Printed) | Signature of Parent/Guardian |

Today's Date

There are three consent forms and one acknowledgement of receipt of notice of privacy practices used by all of the agencies, programs and providers within the Circle of Care. These consents allow the Circle of Care employees to provide you with services, maintain records concerning those interactions, when necessary share information in order to provide you with what you have requested, and releases the Circle of Care and its employees from any and all liability. There is additional consent (optional) regarding the use of your name and/or the use of your children's names in publicity media.

**Parent/Guardian's Name: _____**

**CONSENT FOR SERVICE**

I give my permission for the Circle of Care and its employees to assist me in providing services or accessing services. I do hereby release the Circle of Care and its staff/representatives from any liability which may occur in the process of providing me services or in the process of transportation.

I hereby understand and give the Circle of Care and its staff permission to discuss information related to my family and me and our participations during private consultations with other staff members. I authorize persons appointed by the Executive Director of the Circle of Care for oversight and evaluation purposes, to review my files and records related to services received through the Circle of Care.

I understand this consent will expire when services are terminated or when I withdraw from the program.

_____ _____
Guardian/Primary Care Giver Signature Date

_____ _____
Agency Representative Date

**CONSENT FOR USE OF INFORMATION**

I give my permission for the Circle of Care and its employees to enter any and all of my information into their databases for record keeping and if appropriate to disclose any of the information that I have provided them to a doctor, nurse, clinic or other agency in order to receive services that I may need. I understand that The Circle of Care may use non-identifying information that I provide for research, quality assurance or legal requirements.

_____ _____
Guardian/Primary Care Giver Signature Date

_____ _____
Agency Representative Date

**CONSENT FORMS / PRIVACY PRACTICE NOTIFICATION**
**(Continued)**

**Acknowledgement of Receipt of Notice of Privacy Practices**

I have received a copy of the Circle of Care Center for Families's Notice of Privacy Practices.

_____ _____
Guardian/Primary Care Giver Signature Date

_____ _____
Agency Representative Date

# Acceptable Use Policy

**DEFINITION**

The rules contained in this document apply to ALL computers within the school and/or Growth Academy setting whether they are stand-alone stations, locally networked stations, or Internet access stations. Due to the fact that Internet access reaches beyond the bounds of the school/center setting, special permission from the parent/guardian is required for use of this service.

The Internet is a global network made up of many smaller contributing networks connecting thousands of computers throughout the world and millions of individual subscribers. Internet access is coordinated through a complex association of government agencies and regional and state networks. While there is an abundance of valuable information, with this access comes the availability of material that may not be considered to be of educational value in the context of the school setting.

**RELEASE OF LIABILITY**

The Growth Academy through the Circle of Care Center for Families will attempt in good faith to provide and maintain viable networks and computers for the advancement of instructional goals. The Growth Academy makes no warranties expressed or implied for the quality of Internet service. It is not responsible for any damages including the interception of transmissions beyond its boundaries, loss of data, delays, non-deliveries, or service interruptions caused by its own error or omission or the inability or error of the user. The Growth Academy and its providers deny any responsibility for the accuracy or quality of information obtained through its services. Any statement of personal belief is implicitly understood to be representative of the author's individual point of view and not that of The Growth Academy or the Circle of Care.

**PRIVACY AND RIGHTS**

All users have the right to privacy. This right applies specifically to email accounts and personal directories on center servers. However, if a user is believed to be in violation of the guidelines, Growth Academy staff may review communications to maintain system integrity and to insure the system is used responsibly. The ultimate decision to review personal data rests with the the Circle of Care Director and his/her designees.

Any user who receives threatening or unwelcome communications should bring them to the attention of Growth Academy staff or teacher.

**SPECIFIC RULES**

No profane, abusive, or impolite language should be used to communicate nor should materials be accessed which are not in line with the rules of center behavior.

Graphics and prose from outside sources will be subject to the same rules and standards as published work in the local library.

Artwork and written work on the network will be subject to the same rules and standards as any school work.

Do not use a computer or the Internet to hurt, harass, attack or harm other people or their work.

Do not damage the computer or network in any way.

Do not degrade the performance of the network through the posting of electronic chain letters or other useless information.

Do not use the internet for illegal activities, i.e. threats, instructions on how to perform an illegal act, child pornography, drug dealing, purchase of alcohol, gang activities, etc.

Do not install software or download files, games, programs, or other electronic media without express permission of supervising parties (i.e. instructors, librarian, etc.)

Do not bring personal software or media into school buildings except with the express permission of a supervisor.

Do not violate copyright laws.

Do not view, send, or display obscene, profane, lewd, vulgar, rude, disrespectful, threatening, or inflammatory language, message or pictures.

Do not share your password with another person.

Do not reveal the personal address or phone number of you or anyone else.

Do not re-post non-academic personal communications without the original author's prior consent.

Users have an additional responsibility to report potential or suspected abuse or damage to the center staff.

**RULE CHANGES AND POSTING**

The rules and regulations contained herein will be posted on an accessible web site and in written form on all campuses. They are subject to change by administrators of the system. Major revisions in policy will occasion the notification of all parties involved. Nothing contained in this document should be construed as circumventing or displacing the laws of the United States, State of Alabama, or local entities. The Growth Academy and Circle of Care policy will be applicable in any circumstance not covered here.

**Valley, Alabama 36854**
**334-768-4091**

**Notice of Privacy Practices**

**Effective Date: June 1, 2021**

**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 Notice of Privacy Practices describes how The Circle of Care Center for Families uses and discloses your "protected health information" to arrange treatment, payment, or health care operations; for other purposes that are permitted or required by law; and your rights to access and control your "protected health information". "Protected health information" is general and specific information about you, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to follow the terms of this Notice of Privacy Practices and to make the new notice provisions effective for the "protected health information" that we maintain and use, as well as for any "protected health information" that we may receive in the future. Should the terms of this Notice of Privacy Practices change, we will promptly distribute a revised copy of the notice to you. Revised Notice of Privacy Practices will be available at our office for individuals to take with them and we will post a copy of revised Notice of Privacy Practices in a prominent location in our office.

**PERMITTED USES AND DISCLOSURES OF YOUR HEALTH INFORMATION**

1. **General Uses and Disclosures.** Under the Federal Privacy Rules, we are permitted to use and disclose your health information for the following purposes, without obtaining your permission:
   - **Treatment.** We are permitted to use and disclose your health information in the provision and coordination of your health care. For example, we may disclose your health information to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment.
   - **Payment.** We are permitted to use and disclose your health information for the purposes of determining coverage, billing, and reimbursement. This information may be released to an insurance company, third party payor, or other authorized entity or person involved in the payment of your medical bills and may include copies or portions of your medical record which are necessary for payment of your bill. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.
   - **Health Care Operations.** We are permitted to use and disclose your health information during our health care operations, including, but not limited to: quality assurance, auditing, licensing or credentialing activities, and for educational purposes. For example, we can use your health information to internally assess our quality of care provided to our participants.
   - **Uses and Disclosures Required by Law.** We may use and disclose your health information when required to do so by law, including, but not limited to: reporting abuse, neglect and domestic violence; in response to judicial and administrative proceedings; in responding to a law enforcement request for information; or in order to alert law enforcement to criminal conduct on our premises or of a death that may be the result of criminal conduct.
   - **Public Health Activities.** We may disclose your health information for public health reporting, including, but not limited to: child abuse and neglect; reporting communicable diseases and vital statistics; product recalls and adverse events; or notifying person(s) who may have been exposed to a disease or are at risk of contracting or spreading a disease or condition.
   - **Abuse and Neglect.** We may disclose your health information to a local, state, or federal government authority, if we have a reasonable belief of abuse, neglect or domestic violence.
   - **Regulatory Agencies.** We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs, and compliance with civil rights.
   - **Judicial and Administrative Proceedings.** We may disclose your health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request, or similar legal request.
   - **Law Enforcement Purposes.** We may disclose your health information to law enforcement officials when required to do so by law.
   - **Coroners, Medical Examiners, Funeral Directors.** We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.
   - **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved and where certain the safeguards are in place to ensure the privacy and protection of your health information.
   - **Threats to Health and The Safety.** We may use or disclose your health information if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or the Safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.
   - **Specialized Government Functions.** If you are a member of the U.S. Armed Forces, we may disclose your health information as required by military command authorities. We may also disclose your health information to authorized federal officials for national security reasons and the Department of State for medical suitability determinations.
   - **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your health information to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect our health or the Safety, or the health or the Safety of others; or for the the Safety and security of the correctional institution.
   - **Workers' Compensation.** We may disclose your health information to your employer to the extent necessary to comply with Alabama laws relating to workers' compensation or other similar programs.
   - **Fundraising.** We may use or disclose your health information to make a fundraising communication to you, for the purpose of raising funds for our own benefit. Included in such fundraising communications will be instructions describing how you may ask not to receive future communications.
   - **Marketing.** We may use or disclose your health information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.
   - **Appointment Reminders/Treatment Alternatives.** We may use and disclose your health information to remind you of an appointment for treatment and medical care at our office or to provide you with information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.
   - **Business Associates.** We may disclose your health information to business associates who provide services to us. Our business associates are required to protect the confidentiality of your health information.

One Per Parent/Guardian

- **Other Uses and Disclosures.** In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Federal Privacy Rules.

2. **Uses and Disclosures Which Require Participant Opportunity to Verbally Agree or Object.** Under the Federal Privacy Rules, we are permitted to use and disclose your health information: (i) for the creation of facility directories, (ii) to disaster relief agencies, and (iii) to family members, close personal friends or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. Except in emergency situations, you will be notified in advance and have the opportunity to verbally agree or object to this use and disclosure of your health information.

3. **Uses and Disclosures Which Require Written Authorization.** As required by the Federal Privacy Rules, all other uses and disclosures of your health information (not described above) will be made only with your written authorization. For example, in order to disclose your health information to a company for marketing purposes, we must obtain your authorization. Under the Federal Privacy Rules, you may revoke your authorization at any time. The revocation of your authorization will be effective immediately, except to the extent that: we have relied upon it previously for the use and disclosure of your health information; if the authorization was obtained as a condition of obtaining insurance coverage where other law provides the insurer with the right to contest a claim under the policy or the policy itself; or where your health information was obtained as part of a research study and is necessary to maintain the integrity of the study.

## PARTICIPANT RIGHTS

You have the following rights concerning your health information:

1. **Right to Inspect and Copy Your Health Information.** Upon written request, you have the right to inspect and copy your own health information contained in a designated record set, maintained by or for us. A "designated record set" contains medical and billing records and any other records that we may use for making decisions about you. However, we are not required to provide you access to all the health information that we maintain. For example, this right of access does not extend to psychotherapy notes, or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding. Where permitted by the Federal Privacy Rules, you may request that certain denials to inspect and copy your health information be reviewed. If you request a copy or summary of explanation of your health information, we may charge you a reasonable fee for copying costs, including the cost of supplies and labor, postage, and any other associated costs in preparing the summary or explanation.
2. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations, as well as disclosures to persons involved in your care or payment for your care, such as family members or close friends. We will consider, but do not have to agree to, such requests.
3. **Right to Request an Amendment of Your Health Information.** You have the right to request an amendment of your health information. We may deny your request if we determine that you have asked us to amend information that: was not created by us, unless the person or entity that created the information is no longer available; is not health information maintained by or for us; is health information you are not permitted to inspect or copy; or we determine that the information is accurate and complete. If we disagree with your requested amendment, we will provide you with a written explanation of the reasons for the denial, an opportunity to submit a statement of disagreement, and a description of how you may file a complaint.
4. **Right to an Accounting of Disclosures of Your Health Information.** You have the right to receive an accounting of disclosures of your health information made by us within six (6) years prior to the date of your request. The accounting will not include: disclosures related to treatment, payment or health care operations; disclosures to you; disclosures based on your authorization; disclosures that are part of a limited data set; incidental disclosures; disclosures to persons involved in your care or payment for your care; disclosures to correctional institutions or law enforcement officials; disclosures for facility directories; or disclosures that occurred prior to April 14, 2003.
5. **Right to Alternative Communications.** You have the right to receive confidential communications of your health information by a different means or at a different location than currently provided. For example, you may request that we only contact you at home or by mail.
6. **Right to Receive a Paper Copy of this Notice of Privacy Practices.** You have the right to receive a paper copy of this Notice of Privacy Practices upon request, even if you have agreed to receive this Notice of Privacy Practices electronically.

If you wish to exercise any of these rights, please contact our Case Manager. All requests must be submitted to us in writing on a designated form which we will provide to you and returned to the attention of our Case Manager at the address below:

The Circle of Care Center for Families
Attn: Case Manager
14 Medical Park
Valley, AL 36854
Fax: (334) 768-4058