

# NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: FEBRUARY 16, 2026

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

## PROTECTED HEALTH INFORMATION

This Notice applies to protected health information (PHI) created or received by the UW Autism Center that identifies you; relates to your past, present or future physical or mental condition; relates to the care provided; or relates to the past, present or future payment for your healthcare. For example, PHI includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

## YOUR RIGHTS

When it comes to your protected health information (PHI), you have the right to:

- **See and receive an electronic or paper copy of your health information.** In most cases, you have the right to review and receive a copy of certain healthcare information including certain medical and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Ask for a change or addition to your health information.** If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that we make a correction or add information. You must include a reason for the amendment in your request. We are not required to agree to the amendment of your record, but a copy of your request will be added to your record.
- **Ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.** You must make your request in writing (including email). We will grant all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Ask us to limit what we use or share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service of 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.
- **Ask for a list of persons or entities outside the UW Autism Center with whom we have shared your health information.** Certain instances will not appear on the list, such as disclosures for treatment, payment, or when you have authorized the use or disclosure. Your first accounting of disclosures in a calendar year is free of charge. Any additional request within the same calendar year requires a processing fee.
- **Ask for a paper or electronic copy of this Notice.**
- **Choose someone to act for you.** If you have given medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- **File a complaint if you feel like your privacy rights have been violated.** You may file a complaint with the UW Autism Center or with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter, calling, or emailing. We will not retaliate against you for filing a complaint.

UW Autism Center Compliance Officer; Box 357920; Seattle, WA 98195-7920

206-221-6806, Toll-Free: 877-408-8922; Email: [uwautism@uw.edu](mailto:uwautism@uw.edu)

Department of Health; Health Systems Quality Assurance (HSQA); Complaint Intake; P.O. Box 47857; Olympia, WA 98504-7857; 360-236-4700; **Email:** [HSQAComplaintIntake@doh.wa.gov](mailto:HSQAComplaintIntake@doh.wa.gov)

Office for Civil Rights; U.S. Department of Health and Human Services; Centralized Case Management Operations; 200 Independence Ave. S.W.; Suite 515F, HHH Building; Washington, DC 20201; Customer Response Center: 800-368-1019; Fax: 202-619-3818; TDD: 800-537-7697; Email: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov)  
[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

## OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your PHI.
- We will let you know promptly if a breach occurs that may have compromised the privacy and security of your health information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you give us written permission.

## USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

We may use and disclose your PHI for the following reasons:

**Provide treatment.** Some examples include, but are not limited to:

- Clinicians may need to know and/or discuss your health history to care for you and to understand how to evaluate your response to treatment.

**Payment purposes.** Some examples include, but are not limited to:

- We may use your PHI to prepare claims for payment of services you have received or to communicate with other individuals or agencies to receive payment.
- If you have health insurance and we bill your insurance directly, we will include information that identifies you, as well as your diagnosis, the procedures performed, and supplies used, so that we can be paid for the treatment provided.

**Maintain clinic operations.** We may use and disclose your PHI to support daily activities related to our clinic operations, for example, to monitor and improve our clinic services or for authorized staff to perform administrative activities.

**Train staff and students:** Staff or students who are in training may assist our staff with clinical responsibilities.

**Conduct research.** An Institutional Review Board (IRB) will review each request to use or disclose your PHI to protect the rights, safety, and welfare of research subjects.

**Contact you for information.** Your personal information may be used to call you or send you a letter to remind you about appointments, provide diagnostic results, inform you about treatment options, or advise you about other health-related benefits and services.

**Consult with business associates.** Your health information may be disclosed to individuals or organizations that assist us in our business activities, for example consultants or attorneys. These business associates are required to protect the confidentiality of your information.

## OTHER USES AND DISCLOSURES

We also use and disclose your information to enhance healthcare services, protect patient safety, safeguard public health, ensure that our facilities and staff comply with government and accreditation standards, and when otherwise allowed by federal and state law. For example, we provide or disclose information:

- To government oversight agencies with data for health oversight activities authorized by law, such as auditing or licensure.
- To appropriate government agencies when we suspect abuse or neglect as we are mandated reporters.
- To appropriate agencies or persons when we believe it necessary to avoid a serious threat to health or safety or to prevent serious harm.
- To law enforcement when required or allowed by law.
- For court order or lawful subpoena.
- To government officials when required for specifically identified functions such as national security.

- When otherwise required by law, such as to the Secretary of the United States Department of Health and Human Services for purposes of determining compliance with our obligations to protect the privacy of your health information.

We have to meet many standards set forth by the law before we can share your information for these purposes. For more information, please visit: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>

## USE AND DISCLOSURE REQUIRING YOUR AUTHORIZATION

Other than the uses and disclosures described above, we will not use or disclose your PHI without your written permission. The UW Autism Center requires your written authorization for each individual entity for sale of your information, most sharing of psychotherapy notes, and marketing purposes. You can change your mind at any time about how you authorize us to use your PHI unless disclosure is required for us to obtain payment for services already provided, we have otherwise relied on the authorization, or the law prohibits revocation.

In the cases that require your written authorization, you have both the right and choice to give us permission to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.

For fundraising, we may contact you, but you can tell us not to contact you again.

## ADDITIONAL PROTECTION OF YOUR HEALTH INFORMATION

- State and federal laws apply to certain classes of patient health information. For example, additional protections may apply to information about sexually transmitted infections, substance use disorder (SUD) treatment records from federally assisted programs, mental health records, and HIV/AIDS information. When required by law, we will obtain your authorization before releasing this type of information. We will not share your SUD records from federally assisted programs for legal proceedings against you, unless you consent in writing or a court orders us to do so.

In certain circumstances, a minor (under 18 years of age) patient's health information may receive additional protections. For your protection, we adhere to WAC 246-924-363 & RCW 70.02.230.

## CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this Notice, and the changes will apply to all information we have about you as well as any information we may receive in the future. We will post a copy of the current Notice at each UW Autism Center facility. In addition, each time you visit the UW Autism Center for treatment and other services, you may request a copy of this Notice from the UW Autism Center office. An electronic version of the Notice is posted at [uwautism.org](http://uwautism.org). For more information, please visit: <http://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html>

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Print Client's Name: \_\_\_\_\_

By signing below, I agree with and have received a copy of the UW Autism Center Notice of Privacy Practices.

\_\_\_\_\_  
**Signature** (Parent/Guardian if under 18)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Relationship to Client**

\_\_\_\_\_  
**Signature of Client** (If Client is 13 yrs. or older)

\_\_\_\_\_  
**Date**