



## Montgomery County Department of Health and Human Services Notice of Privacy Practices Summary and Signature Page

### What is the Notice of Privacy Practices?

We are required by law to provide you with a notice of our privacy practices. Our complete *Notice of Privacy Practices* is attached. The purpose of the *Notice* is to inform you about:

- Our legal obligation to protect your information.
- How we will share your information without your written permission.
- Rights that you have related to your information.
- Who you can contact to ask questions, make a request, or file a complaint.

### How will we share your information?

Our Department provides a variety of health, income support and social services. To provide these services, we must ask you for personal information that may contain health, financial and other information that identifies you. We will keep your information safe and will only share it when the law permits us or requires us to do so. We will share your information as necessary to:

- Provide you with high quality and coordinated treatment and services.  
Example: Communicating information between programs to make referrals, determine eligibility or develop a care plan;
- Obtain payment for services. Example: Billing Medicaid;
- Manage our services and programs. Example: Reviewing the quality of the services you receive.

The attached *Notice* lists other reasons why we may share your information. If we need to share your information for reasons that are **not** listed, we will ask for your written permission. You have other rights related to your information that are listed on page 4 of the *Notice*.

### Contact Information:

If you have questions about our privacy practices, want to make a request related to your information, or have a privacy concern, contact the staff person who is working with you, or our Privacy Official at 240 777- 1295. Additional contact information is provided at the end of the *Notice*.

Acknowledgement of receipt of the complete *Notice*:

\_\_\_\_\_  
Client or Authorized Representative (Sign your name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print your name

\_\_\_\_\_  
Signature of DHHS representative

\_\_\_\_\_  
Signature of interpreter/translator if applicable

If unable to get acknowledgement, specify why: \_\_\_\_\_