2019 Confidentiality & HIPPA
For Hippotherapy Clients

From the WCR's Employee Handbook regarding confidentiality:

WCR's policy is to ensure that the operations, activities, and business affairs of WCR and its client are kept confidential to the greatest possible extent. WCR recognizes the right of riders and their families for privacy and control over any information about them that might be personal or sensitive. In order to respect that right, WCR has adopted this policy regarding confidentiality. If during their association with WCR, individuals acquire confidential or proprietary information about WCR and its clients; such information is to be handled in strict confidence and not to be discussed with persons not connected with WCR activities.

Those bound by the directives of this policy are all persons in any way connected with WCR, including but not limited to: full and part time staff, volunteers, board members, temporary employees, independent contractors, and instructor workshop/training/certification participants. Any individuals violating this policy will be subject to disciplinary action including reprimand, alteration of job responsibilities, and termination of employment or volunteer responsibilities.

Information considered to be confidential includes all medical, social, referral, personal, and financial concerns regarding a rider and his or her family. Such information is considered confidential regardless of how it is obtained, whether directly from the rider of family or inadvertently from a chart, computer screen, or overheard conversation.

Consent to disclose information to outside individuals or agencies, including photograph and videotapes, should be obtained in writing from the proper legal representative. For most children under the age of 18, this would be the parent or legal guardian. Adults over 18 with developmental disabilities are presumed to be competent to give consent unless they have specifically been found incompetent in a court of law. In such a case, a substitute decision maker is assigned, and consent must be obtained from that person.

CONFIDENTALITY
In day to day center operations WCR will do the following to safeguard participant confidentiality:

1. Ensure that all fellow employees, volunteers, and visitors read and sign the confidentiality policy.
2. Conduct conversations about participant's progress, medical changes, goals, or anything else that might be considered private, in a confidential and private place.
3. Posted information will not include the participant's last name unless express permission has been obtained.
4. The drawers containing participant files will be locked as part of the daily closing procedures.
5. Instructors will share with volunteers only what they need to know to be safe and effective in their role as horse leader or side walker.

HIPPA

In addition to the above, all participants who are seen at WCR by a therapist (e.g. hippotherapy) must also, by law, sign a WCR HIPPA form (outside agencies sometimes also require their own form to be signed), the text of which follows below.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO HIPAA (Health Insurance Portability and Accountability Act of 1996)

I give permission for the staff and therapists of the We Can Ride Inc. to contact appropriate physicians and health care providers as necessary and related to my treatment at WCR. I give permission for WCR staff and therapists to share information with one another as appropriate and related to treatment. I authorize WCR staff and therapists to perform treatments necessary and to make referrals as needed. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

I agree that these provisions will remain in effect until I provide written revocation to WCR. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization.

I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned upon my execution of this authorization. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Client Name:_____Date:_____

Self or Guardian Printed Name:_____

Signature(Guardian signature required if under 18):_____