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NOTICE OF PRIVACY PRACTICES

To my clients: *I am required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how medical/psychological information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

I. MY PLEDGE IN REGARD TO YOUR HEALTH INFORMATION:

This notice will tell you about the ways in which I may use and disclose health information about you. I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. This notice applies to all the records of your care produced by my practice. I need this record to provide you with superior care and to comply with certain legal requirements. I will also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private. (Your **Protected Health Information (PHI)** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you).
- Follow the terms of the notice that is currently in effect.
- Provide this notice of my legal duties and privacy practices with respect to health information.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. IN THE EVENT THAT I DISCLOSE INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways I am permitted to use and disclose information, will fall within one of the categories.

III. Some uses, and disclosures require your authorization:

1. **Psychotherapy Notes.** I do keep “psychotherapy notes” and any disclosure or use of such notes requires your Authorization unless the use or disclosure is:
 - a. For my use in legal proceedings instituted by you, to protect myself.
 - b. For my use in providing services to you.
 - c. In the investigation by the Secretary of Health and Human Services for my compliance with HIPAA.

- d. For certain health oversight activities pertaining to the originator of the psychotherapy notes, that are required by law.
 - e. Required by law and the use or disclosure is limited to the requirements of such law.
 - f. Required to help avert a serious threat to the safety and health of others.
 - g. Required by a coroner in the performance of duties.
2. **Marketing Purposes.** As a psychotherapist, I will not disclose your PHI for marketing purposes.
 3. **Sale of PHI.** I will not sell your PHI, during my business, for any reason.

IV. MY USE AND DISCLOSURE OF HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization. This applies to circumstances necessary to carry out the health care provider's own treatment, payment, or health care operations. I may also disclose your PHI for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition. This is within the guidelines of PHI disclosure.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care, they will acquire your PHI from other physicians involved in your care, in order to provide the best quality of treatment. The word "treatment" includes, among other things, the direction and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

V. I may use or disclose PHI without your consent or authorization in the following situations:

1. **Child Abuse:** I am required by law to report to the proper law enforcement authorities, if I have reasonable cause to believe that a child has suffered abuse or neglect.
2. **Health Oversight:** In the event the State Department of Health subpoenas me as a part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of

licensure to therapists, it will be necessary for me to comply. This may include disclosing your relevant mental health information.

3. **Adult and Domestic Abuse:** I must immediately report to the proper enforcement authorities, if I have reasonable cause to believe that abuse, abandonment, financial exploitation, physical or sexual assault, or neglect of a vulnerable adult has occurred.
4. **Serious Threat to Safety or Health:** I may disclose your mental health information to anyone without authorization, if I reasonably believe that disclosure will avoid or minimize imminent danger to your safety or the health or safety of any other individual.
5. **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, I will release information only with the written authorization of you/your legal representative, or a subpoena or court order. (This privilege does not apply when you are being evaluated for a third party or for the court; You will be informed in advance if this is the case.)
6. **Worker's Compensation:** If you file a worker's compensation claim, I must make all relevant health information in my possession available to your representative, your employer, and the Department of Labor and Industries upon their request.

CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others. I may provide your PHI to a family member, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. **The Right to Request limits for Out-of-Pocket Expenses Paid for In Full.** You have the right to request limits on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
2. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask me to not disclose or use certain PHI for treatment, payment, or health care operations purposes. I may not agree to your request, and I may say "no" if I believe it would affect your health care.
3. **The Right to See and Get Copies of Your PHI.** Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
4. **The Right to Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
5. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.
6. **The Right to Get a List of the Disclosures I Have Made.** You have the right to request a list of occurrences in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for a statement of disclosures within 60 days of receiving your

request. The list I will give you will include releases made in the last six years unless you request a shorter time. I will provide the list to you at no charge.

7. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct or add to the existing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on: _____

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

SIGNATURE OF PATIENT: _____

DATE: _____

SIGNATURE OF PARENT/GUARDIAN (if patient is under 18):

Date: _____