

## **HIPAA Notice of Privacy**

The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you sign a release of information, or unless the law authorizes or requires me to do so.

A federal law commonly known as "HIPAA" requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of this Notice.

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

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this HIPAA Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

#### **I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

##### **A. Permissible Uses and Disclosures without Your Written Authorization**

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below.

**1. Treatment:** I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment with your consent.

**2. Payment:** I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

**3. Required or Permitted by Law:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a current victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

##### **B. Uses and Disclosures Requiring Your Written Authorization**

**1. Psychotherapy Notes:** Notes recorded by me documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by me and will not otherwise be used or disclosed without your written authorization.

**2. Marketing Communications:** I will not use your health information for marketing communications without your written authorization.

**3. Other Uses and Disclosures:** Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign

an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

## **II. YOUR INDIVIDUAL RIGHTS**

**A. Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you

**B. Right to Alternative Communications.** You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

**C. Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.

**D. Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

**E. Right to Request Amendment:** You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

**F. Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

**G. Questions and Complaints.** If you desire further information about your privacy rights, want additional copies of this Notice, or are concerned that Nancy Duffey Black, MS, LICSW, CEAP LPCC has violated your privacy rights, you may contact the Privacy Officer, Nancy Duffey Black, MS, LICSW, CEAP. (myself since I am a sole proprietor). Upon request, I will provide you with the address of the Director, Office for Civil Rights of the U.S. Department of Health and Human Services, where you may file written requests. I support your right to the privacy of your health information. I will not retaliate against you if you file a complaint with the Director or me.

## **III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE**

**A. Effective Date.** This Notice went into effect on April 14, 2003.

**B. Changes to this Notice.** I may change the terms of this Notice at any time in accordance with applicable law. Prior to making significant changes to my privacy practices, I will alter the Notice to reflect the changes and make the revised Notice available to you on request. Any changes I make to privacy practices and/or this Notice may be applicable to health information created or received by me prior to the date of the changes. By signing below, I acknowledge receiving a copy of this Notice of HIPPA Privacy Practices.

\_\_\_\_\_ Date \_\_\_\_\_