

# Privacy Practices

## HIPAA: Notice of Privacy Practices for Protected Health Information (PHI)

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) is a Privacy Rule that requires that I provide a Notice of Privacy Practices. This notice describes whether and how I may use and disclose your Protected Health Information (PHI) for the purposes of treatment, payment and healthcare operations and how you can gain access to this information. This notice also includes how to file a complaint if you believe your privacy rights have been violated. HIPAA requires that I obtain your signature acknowledging that I have provided you with this notice. Please read it carefully. Your signature must be provided for us to proceed with treatment.

HIPAA protects the privacy of all communication between a client and a therapist. I am also committed to maintaining the confidentiality and privacy of all information shared during therapy. In most situations I am permitted to release information about your treatment to others only if you sign a written authorization form that meets the HIPAA requirements.

## LIMITS TO CONFIDENTIALITY

Information disclosed during therapy sessions will be kept strictly confidential except under circumstances described in this notice. There are some situations in which I am permitted or required to disclose information without either your consent or authorization. If this situation arises, I will limit what I disclose to only what is necessary.

### *Risk of Harm to Self or Others*

- If, in my professional opinion, you are in immediate danger of harming yourself, I may be required to seek hospitalization for you or to contact family members or others who can help provide protection. Once such a report is filed, I may be required to provide additional information.
- If I suspect that you pose an immediate threat to harm another person, I am required to act which includes, but is not limited to, notifying the potential victim, and/or appropriate family member, and/or the police or to hospitalize you. Once such a report is filed, I may be required to provide additional information.
- If I have reason to suspect child or elder abuse or neglect or abuse of a disabled or vulnerable person, I am required to report to the appropriate agency. A child is anyone under 18 years of age. An elder is a person 60 years and older. Once such a report is filed, I may be required to provide additional information.

### *My Legal Obligations*

If you are involved in a court proceeding, your PHI is protected by the therapist-client privilege law. I cannot provide any information about your diagnosis or treatment without your or your legal representative's written authorization except under certain circumstances. These are:

- If I receive a court order or a subpoena of which you have been properly notified and you have not informed me that you oppose the subpoena. (If you are involved in or contemplating a lawsuit, please consult with an attorney to determine whether a court would be likely to order me to disclose any of your PHI.)
- If a government agency is requesting information for health oversight activities within its legal authority, I may be required to provide it.
- If you file a complaint or lawsuit against me, I may disclose relevant information regarding your treatment to respond to the complaint in order to defend myself.
- If you file a Workers' Compensation claim, I will be required to provide your treatment records relevant to that claim. These records will not be confidential to entities such as your employer, the insurer, a rehabilitation provider, and the Division of Worker's Compensation.
- If you use an EAP (Employee Assistance Program) to pay for all or part of your treatment, information regarding your diagnosis and treatment may be shared with their representative.
- I may consult with other mental health professionals about your care. This will be done in accordance with HIPAA standards.

- I reserve the right to change the terms of this notice and will notify you if I do. A copy of the new notice will be available upon request.

#### *Permitted and Required Uses and Disclosures of Your PHI*

Under certain circumstances your PHI may be used and disclosed outside.

- **Treatment:** Should I need to speak with or provide information to another provider outside my office to coordinate care, I will request that you sign an authorization known as a Release of Information.
- **Payment:** I may use and disclose your health information to obtain payment for services provided. This is fully explained in the *Informed Consent for Services and Practice Policies*.
- **As Required by Law:** As required by law I may release your PHI to one or more governmental agencies or departments concerned with public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, criminal activity, military activity and national security, workers' compensation, inmates, insurance audits, and other required uses and disclosures.

#### **YOUR RIGHTS**

The following are your rights with respect to your PHI.

- **Right to Treatment:** You have the right to be treated in a manner which is ethical and free from abuse, discrimination and/or exploitation. To be treated with respect no matter your age, culture, ethnicity, religion, gender, sexual orientation, sexual preference, size, weight, and ability.
- **Right to Inspect and Copy Your PHI:** You have the right to inspect or obtain a copy (or both) of your PHI. Requests must be in writing and a release of information must be completed. Please allow two weeks to receive your copy. A fee may apply of \$0.50 per page. You may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, PHI restricted by law, information related to medical research in which you have agreed to participate, information obtained under a promise of confidentiality or information that may result in harm or injury to you or to another person. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- **Right to Request Restrictions of Your PHI:** You have the right to request restrictions on certain uses and disclosures of your protected health information. Your request must state the specific restriction requested and to whom you want it to apply. However, I am not required to agree to a restriction you request. If I disagree, I will send you a written response within 60 days.
- **Right to Revoke Authorization:** You have the right to revoke your authorization at any time in writing, except when I have already taken action, and the information has already been disclosed.
- **Right to Receive Confidential Communications of PHI by Alternative Means and at an Alternative Locations:** Alternatives include choosing a specific mode of communication (e.g., email, phone, or postal mail) that aligns with your privacy preferences. It also means choosing an alternative address to send letters or other written communications.
- **Right to Amend:** If you believe the information in your records is incorrect and/or is missing important information, you have the right to disagree in writing, to ask me to make specific changes, and explain the reasons you want these changes made. I have the option to write a rebuttal and provide you with a copy of the rebuttal.
- **Right to a Copy of This Notice:** You are entitled to receive a paper copy of this notice at your request even if you have one delivered electronically.
- **Right to an Accounting:** You have the right to receive an accounting of disclosures, which is a list of instances your PHI was shared with someone outside of my practice. You may request an accounting of disclosures for the past five years but not disclosures older than five years. Should you request an accounting, I will discuss additional details of the accounting process.
- **Right to Release Information:** With your written consent, you have the right to authorize the release of any part of your record to a person or organization of your choice. We will discuss the potential impact of sharing this information and whether I believe it could be harmful to you.
- **Right to Have Someone to Act for You –** If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action. If I cannot reasonably determine the validity and authority of your

guardian, I will not reveal your PHI.

- **Right to Receive Notice of a Breach:** I will notify you if your unsecured PHI has been breached and how I am handling the situation.
- **Right to Decline Services – Unless Court-ordered,** you have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- **Right to Terminate –** You have the right to terminate therapeutic services with me (unless court ordered) at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone / text / email letting me know you are terminating services.

## COMPLAINTS

If you believe that I have violated your privacy rights, you may file a complaint with the Secretary of Health and Human Services. You may also communicate directly with me. I will not retaliate against you for filing a complaint.

[U.S. Department of Health and Human Services](#)

200 Independence Ave., SW

Washington, DC 20201

1-877-696-6775

**By signing this document, you acknowledge that you have read, been given the opportunity to ask questions, and understand the confidentiality and privacy policies outlined in the HIPAA: Notice of Privacy Practices for Protected Health Information and have been offered a printed copy of this policy practice.**

*If both parents are involved in the child's or adolescent's life, it is best that both parents sign this consent.*



Template library

Intake documents, progress notes, treatment



**Shareable documents**

Manage default intake documents and upload

Client notifications



Messaging

