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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO YOUR RECORDS, YOUR RIGHTS IN CONTROLLING PHI (Personal Health Information). PLEASE REVIEW IT CAREFULLY. OU MAY HAVE ADDITIONAL RIGHTS UNDER STATE AND LOCAL LAW. PLEASE SEEK LEGAL COUNSEL FROM AN ATTORNEY LICENSED IN YOUR STATE IF YOU HAVE QUESTIONS REGARDING YOUR RIGHTS TO HEALTH CARE INFORMATION.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
Under the Health Insurance Portability and Accountability Act of 1996 (hereafter, "HIPAA"), you have certain rights regarding the use and disclosure of your protected health information (hereafter, "PHI").

MY PLEDGE REGARDING HEALTH INFORMATION

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 record helps to provide you with quality care and complies with certain legal requirements. This Notice of Privacy Practices describes how I may use and disclose health information about you in accordance with applicable law and the LMHC Code of Ethics. I also describe your rights to the health information I keep about you and certain obligations I have regarding the use and disclosure of that information. I am required by law to:

- Make sure that protected health information (PHI) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I reserve the right to revise my practices (in accordance with the law) at any time. You will be notified of any changes in writing.

HOW I MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment: With your written consent I may disclose PHI to other health care providers who have a direct treatment relationship with the client to provide, coordinate and manage treatment or services. I may communicate with your Primary Care Physician, your insurance Company or any other provider involved with your care.

Payment: I may use and disclose PHI to receive payment from a third party (such as your insurance company) for treatment and services provided to you. Examples of payment-related activities include making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. In addition, if you pay with a credit card it will be kept on file for any payments.

CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION/WRITTEN CONSENT

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in-group,
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION

- **Abuse/Neglect:** I am mandated by law to report any suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

- **Harm to Self or Others:** I am required to take reasonable steps to protect your safety and the safety of others in situations of possible suicide, homicide, or violence. This includes my “duty to warn” if you are making specific threats toward individual(s).
- **Mandatory Government Audits or Investigations:** Examples include Mental Health licensing board or health department.
- **Court Order:** For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
- **National Security:** Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

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

You have the right and choice to tell me that I may provide your PHI to a family member, friend, or other person whom you indicate is involved in your care or the payment for your health care, or to share you information in a disaster relief situation. The opportunity to consent may be obtained retroactively in emergency situations to mitigate a serious and immediate threat to health or safety or if you are unconscious.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to **Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care, but I will document your disagreement in the record.
2. The Right to **Request Restrictions for Out-of-Pocket Expenses Paid for In Full**. You have the right to request restrictions 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.
3. 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.
4. 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, or a summary of it, if you agree to receive a

summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

5. 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 the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request. I will document your disagreement in the record.
6. 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.
7. The Right to **Get a Paper or Electronic Copy of this Notice.** You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.
8. The Right to **Choose Someone to Act For You**. If you have given someone medical power of attorney or if someone is your legal guardian, that person can make choices about your health information.
9. The Right to **Revoke an Authorization**.
10. The Right to **Opt out of Communications** and Fundraising from our Organization.
11. The Right to **File a Complaint**. You can file a complaint if you feel I have violated your rights by contacting me using the information on page one or by filing a complaint with the HHS Office for Civil Rights located at 200 Independence Avenue, S.W., Washington D.C. 20201, calling HHS at (877) 696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

The terms of this Notice are subject to change. You will be notified of such policy changes and the new Notice will be available on my website.

Effective date: January 2019 Revised November 2023