Therapy Department

9550 Warner Ave., Suite 250-17, Fountain Valley, CA 92708

HIPAA DISCLOSURE Effective Date of Notice: 1-1-17

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how medical information about you, including that involving mental health treatment and psychological services may be used and disclosed, and how you can gain access to this information. Please review it carefully.

HIPAA PRIVACY INFORMATION

HIPAA (Health Insurance Portability and Accountability Act) is a federal law that defines Protected Health Information (PHI) and mandates its protection by the providers of certain health care services. It is important that you know the general rights and obligations directed by this law. Please contact our office if you have any questions about PHI and our confidentiality practices.

HIPAA PRIVACY NOTICE FORM

Notice of Mental Health Practitioners Policies and Practices to Protect the Privacy of Your Health Information.

This notice describes use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment, and conducting healthcare operations are necessary for quality care. State and federal laws allow me to use and disclose your health information for these purposes. Mental health, psychological, and medical information about you may be used and disclosed and how you can gain access to this information.

I. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**

Therapy Department may use or disclose your protected health information (PHI) for treatment, payment, and health care operation purposes with your consent. To help clarify these terms, here are some definitions:

1. Protected health information (PHI) refers to information in your record that could identify you.
2. Treatment is when Therapy Department provides, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when Therapy Department consults with another health care provider, such as your family physician or another mental health professional.
3. Payment refers to the fees you pay me for services. Health care operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
4. Use applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
5. Disclosure applies to activities outside this practice, such as releasing, transferring, or providing access to information about you to other parties.

II. **Uses and Disclosures Requiring Authorization**

Therapy Department may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Therapy Department is asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. Therapy Department will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes contain documentation of my work with you and include, but are not limited to, our conversations during individual, group, joint, and family counseling sessions, which Therapy Department has kept separate from the rest of your medical record. These notes are given greater degree of protection than PHI. You may revoke all such authorizations at any time, providing each revocation in writing.

III. **Uses and Disclosures with Neither Consent Nor Authorization**

Therapy Department may use or disclose PHI without your consent or authorization in the following circumstances:

1. Child Abuse: If we know, or have reasonable cause to suspect that a child is abused, abandoned or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that Therapy Department report such knowledge or suspicion to the appropriate authorities.
2. Adult and Domestic Abuse: If Therapy Department knows, or has reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected or exploited, we are required by law to report such knowledge or suspicion to the Central Abuse Hotline.
3. Health Oversight: If a complaint is filed against anyone at Therapy Department with the State Board, the board has the authority to subpoena confidential mental health information from me relevant to that complaint.
4. Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment records, such information is privileged under state law. Therapy Department will not release this information without a written authorization from you or your legal representative, or a subpoena of which you have been properly notified. The privilege does not apply when you are being evaluated for a third party or when the evaluation is court-ordered. You will be informed in advanced if this is the case.
5. Serious Threat to Health Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals or to society, Therapy Department may communicate relevant information concerning this to the potential victim, appropriate family member, law enforcement agency or other appropriate authorities.
6. Worker's Compensation: If you file a worker's compensation claim, Therapy Department must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. **Patient Rights**

1. Right to Request Restriction: You have the right to request restrictions on certain uses and disclosures of protected health information about you. This request to restrict requests must be made in writing. However, we are not required to agree to a restriction request.
2. Right to Receive Confidential Communication by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me.

   Upon your request, we will send your bills to another address.
   Right to request where I contact you as follows (please check):
   Home ___ Yes ___ No Number: _____
   Cell ___ Yes ___ No Number: _____
   Email ___ Yes ___ No Email: _____
   Address for billing: _____

3. Right to Inspect and Copy: You have the right to inspect or obtain a copy of PHI in my mental health and billing records for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may be denied access to Psychotherapy Notes if we believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. We shall notify you or your representative if we do not grant complete access. On your request, we will discuss with you the details of the request and denial process. We do charge an administrative fee for coping of pages 1-25 at 50 cents and each additional page at $25 cents. Also, if any copies need to be mailed there will be a charge for postage. Upon your request, we will discuss with you the details of the request process.

4. Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
5. Right to Accounting: You generally have the right to receive accounting of disclosures of PHI regarding you. On your request, Therapy Department will discuss with you the details of the accounting process.
6. Right to Paper Copy: You have the right to obtain a paper copy of the notice from me, upon request, even if you have agreed to receive the note electronically.

V. **Mental Health Practitioner Duties**
Therapy Department is required by law to maintain privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. Therapy Department reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide a revised notice in person or through mail.

VI. **How to Complain About My Privacy Practices**
If, in your opinion, anyone at Therapy Department may has violated your privacy rights, or if you object to a decision we made about access to your PHI, we ask that you notify me first at Therapy Department, 9550 Warner Ave., Suite 250-17, Fountain Valley, CA 92708. You may also send a written complaint to the Secretary of Department of Health and Human Services at: 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, we will take no retaliatory action against you.

VII. **Person to Contact for Information About This Notice or to Complain About My Privacy Practices**
If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of Department of Health and Human Services, please contact me first at Therapy Department, 9550 Warner Ave., Suite 250-17, Fountain Valley, CA 92708.

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures we may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record:
    - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
    - We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information:
    - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
    - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- 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 exercise your rights and make choices about your health information.
    - We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated:

    - You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.
- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
    - Share information with your family, close friends, or others involved in your care
    - Share information in a disaster relief situation
    - Include your information in a hospital directory
- In these cases, we never share your information unless you give us written permission:
    - Marketing purposes
    - Sale of your information
    - Most sharing of psychotherapy notes
    - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- Treat you – We can use your health information and share it with other professionals who are treating you.
- Run our organization – We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Bill for your services – We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
- Help with public health and safety issues.
- We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- Do research – We can use or share your information for health research.
- Comply with the law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests – We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director – We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
    - To respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
    - For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.
- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

CONSENT TO TREATMENT

Your signature below indicates that you have read the office policies, have been offered a copy of the HIPAA document, understand the Notice of Privacy Practices, and that you are completely responsible for full payment of fees - you are responsible to understand exactly what services your insurance policy covers.

_____	_____	_____
Client Signature	Client Name (PRINT)	Date
_____	_____	_____
Parent Signature (if 17 or younger)	Parent Name (PRINT)	Date
_____	_____	
Witness	Date	

Copy given to client? ___ Yes ___ No Client does not want copy? Client Signature: _____