EMBRACING IMPERFECTION LLC
Joanie Anderson, LMHC
9307 Bayshore Dr. NW
Silverdale, WA 98383
360.276.2467

NOTICE OF PRIVACY PRACTICES

HIPAA Privacy Acknowledgement Form

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 (PHI). This Notification of Privacy Practices informs you of your rights as it relates to your health care records.

In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and I will do all I can to protect the privacy of your mental health records. If you have questions regarding matters discussed in this Notice of Privacy Practices, please do not hesitate to ask.

I. UNDERSTANDING HIPAA PRIVACY

I understand that health information about you and your health care is personal, and I am committed to protecting health information about you. A record will be created of the care and services you receive from me, which is necessary to provide you with quality care and comply with certain legal requirements. This notice applies to all records of your care generated by this mental health care practice and will describe how I may use and disclose health information about you. I also describe certain obligations I have regarding the use and disclosure of your health information.

I am required by law to:

- Make sure PHI that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices concerning your health information.
- Follow the terms of the notice that is currently in effect.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that I use and disclose health information. 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 Payment of Treatment or Health Care Operations: Federal privacy rules and regulations allow health care providers who have a direct treatment relationship with you to use or disclose your PHI without your written authorization for operations purposes such as sending appointment reminders, billing invoices, and other documentation, or provide information for payment of treatment.

Lawsuits and Disputes: If you are involved in a lawsuit, I may be asked to disclose health information in response to a court or administrative order. I may also disclose health information about you or your minor child/children 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.

III. USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

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 defending myself in legal proceedings instituted by you.
    c. For use by the Secretary of the Department of Health and Human Services (HHS) to investigate my compliance with HIPAA.
    d. Required by law and the use or disclosure is limited to the requirements of such law.
    e. Required by law for certain health oversight activities about the originator of the psychotherapy notes.
    f. Required to help avert a serious threat to the health and safety of others.

2. **Marketing Purposes.** I will not use or disclose your PHI for marketing purposes without your prior written consent. This would only apply if you provided a review of my services for marketing purposes, which I do not intend to utilize on my website at this time.

IV. USES AND DISCLOSURES NOT REQUIRING CONSENT OR AUTHORIZATION

By law, Protected Health Information may be released without your consent or authorization under the following conditions:

1. To contact you about appointment reminders, send you information/resources to support the therapy process, or tell you about treatment alternatives or other health care services.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order or subpoena, my preference is to obtain authorization from you before doing so if I am so allowed by the court or administrative officials.
5. For serious threats to health and safety, such as "Duty to Warn" or threats to national security.

V. YOUR RIGHTS CONCERNING 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 if I believed it would affect your health care.
2. **The Right to Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (e.g., home or office phone) or to send mail to a different address, and I will consider all reasonable requests.
3. **The Right to See and Obtain Copies of Your PHI.** Other than in limited circumstances, you have the right to request an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy within 14 business days of receiving your written request. I may charge a reasonable cost-based fee for doing so.
4. **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.

5. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right to get a paper or electronic copy of this Notice.
6. **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.
7. **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 by calling 877.696.6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

VI. CHANGES TO THIS NOTICE

I can change the terms of this Notice, and such changes will apply to all the information I have about you. The new Notice will be available upon request.

VII. EFFECTIVE DATE OF THIS NOTICE

This Notice went into effect on March 25, 2023.

ACKNOWLEDGEMENT OF RECEIPT
I have read this Notice of Privacy Practices from Joanie Anderson LMHC/Embracing Imperfection LLC and acknowledge receipt and understanding of this Notice.

Client Signature: ____

Date: ____

Printed Name: ____

Rev. July 2023