OHIO NOTICE OF PSYCHOLOGISTS'/SPEECH PATHOLOGISTS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

This notice describes how psychological, speech/language, and medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations

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

- *"PHI"* refers to information in your health record that could identify you.
- *Treatment, Payment and Health Care Operations"*

  Treatment is when your provider provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your provider consults with another health care provider, such as your family physician or another psychologist.

  Payment is when your provider obtains reimbursement for your healthcare. Examples of payment are when your provider discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility of coverage.

  Health Care Operations are activities that relate to the performance and operation of your provider's practice. Examples of health care operations are audits, case management, and care coordination.
- *"Use"* applies only to activities within your provider's office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside your provider's office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures of PHI Requiring Authorization

For uses and disclosures beyond treatment, payment and operations purposes your provider is required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. An *"authorization"* is written permission above and beyond the consent that permits only specific disclosures. In those instances when your provider is asked for information for purposes outside of treatment, payments, and health care operations, your provider will obtain an authorization from you before releasing this information. Your provider will also need to obtain an authorization before releasing your therapy notes. *"Therapy notes"* are notes that your provider keeps pertaining to your therapy sessions or evaluations, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or therapy notes) at any time, provided that each revocation is in writing.

III. Uses and Disclosure of PHI Not Requiring Consent nor Authorization

The law provides that your provider may use/disclose your PHI from mental health records without consent or authorization in the following circumstance:

Child Abuse: If, in your provider's professional capacity, your provider knows or suspects that an individual under 18 years of age, or a developmentally disabled adult has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates

abuse or neglect, your provider is required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

Adult or Domestic Abuse: If your provider has reasonable cause to believe that a disabled adult is being abused, neglected or exploited, or is in a condition which is the result of abuse, neglect or exploitation, your provider is required by law to immediately report such belief to the County Department of Job and Family Services.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis or treatment and the records thereof, such information is privileged under state law and your provider will not release this information without written authorization from you or your persona or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If your provider believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, your provider may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to your provider an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and your provider believes that you have the intent and ability to carry out the threat, then your provider is required by law to take one or more of the following actions in a timely manner: (1) take steps to hospitalize you on an emergency basis, (2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, (3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: (a) nature of the threat, (b) your identity, and (c) the identity of the potential victims(s).

Worker's Compensation: If you file a worker's compensation claim, your provider may be required to give your mental health information to relevant parties and officials.

IV. Patient's Rights Regarding Your Protected Health Information

Your have the following rights relating to your PHI:

To request restrictions on uses/disclosures: You have the right to ask that your provider limit how to use or disclose your PHI. Your provider will consider your request, but is not legally bound to agree to the restriction. To the extent that your provider does agree to any restrictions on our use/disclosure of your PHI, your provider will put the agreement in writing and abide by it except in emergency situations. Your provider cannot agree to limit uses/disclosures that are required by law.

To receive confidential communications by alternate means and at alternate locations: For example, you may not want other family members to know that you are receiving psychological services. Upon your request, your provider will send your bills to another address.

To inspect and request a copy of your PHI: Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to inspect or obtain a copy (or both) of PHI and therapy notes in your provider's healthcare and billing records used to make decisions about you for as long as the PHI is maintained in the record. If your provider denies your access, your provider will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

To request amendment of your PHI: If you believe that there is a mistake or missing information in your provider's record of your PHI, you may request, in writing, that your provider correct or add to the record. Your provider may deny the request if your provider determines that the PHI is (1) correct and complete: (2) not created by your provider and/or not part of your provider's records; or (3) not permitted to be disclosed. Any denial will state reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If your provider approves your request for amendment, your provider will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

To find out what disclosures have been made: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, your provider will discuss with you the details of the accounting process.

To a paper copy: You have right to receive a paper copy of this Notice and/or electronic copy by email upon request.

V. Provider's Duties

- Your provider is required by law to maintain the privacy of PHI and to provide you with a notice of your provider's legal duties and privacy practices with respect to PHI.
- Your provider reserves the right to change the privacy policies and practices described in this notice. Unless your provider notifies you of such changes, however, your provider is required to abide by the terms currently in effect.
- If your provider revises these policies and procedures, your provider will notify you in writing and provide a written copy of my revised policies and procedures either in person, by mail, or by email.

VI. Complaints

If you think that your provider may have violated your privacy rights, or you disagree with a decision that your provider makes about access to your PHI, you may discuss the situation with your provider free of charge. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. Your provider will provide you with the appropriate address upon request.

VII. Effective Date

This notice is effective on January 1, 2017.

Your provider reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that your provider maintains. Your provider will provide you with a revised notice by mail or by email.

By signing below you indicate that you have received, understand, and agree to the provisions of this copy of the Notice of Privacy Practice for your provider within the Macks Psychology Group.

_____ _____

Patient Name Date of Birth

_____ _____ _____

Signature of Patient, Parent or Guardian Relationship to Patient Date