

**NEBRASKA HIPPA NOTICE FORM**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

I may *use* or *disclose* your *protected health information (PHI),* for *treatment, payment and healthcare operation* p*urposes with your* consent.

* PHI refers to information in your psychological health record that could identify you.
* Treatment, Payment, and Healthcare Operation
* Treatment is when I provide, coordinate or manage your health care and other services related to your mental health. I.E. Would be when I consult with another mental health provider, therapist or psychologist.
* Payment is when I obtain reimbursement for your healthcare. I.E. When I disclose your PHI to your health insurer to obtain reimbursement for your mental health care of to determine elibility or coverage.
* Healthcare Operations are activities that relate to the performance and operation of my practice. I.E. Are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
* “*Use”* applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* “*D*isclosure” *applies to activities outside of my office I.E. releasing, transferring, or providing access to information about you to other parties.*

1. **Use and disclosures requiring Authorization**

* I may use or disclose PHI for purposes outside treatment, payment, or healthcare 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 I am asked for information for purposes of outside treatment, payment or healthcare operations, I will obtain and authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes, “*Psychotherapy notes”* are my notes I have made about our conversations during private, group, joint, and family counseling sessions, which I have kept separate from the rest of your Psychological record. These notes are given greater degree of protection Under HIPPA PHI Mental Health section.
* You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may revoke an authorization to the extent that (1) I have relied on the authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

1. **Uses and Disclosures with Neither Consent nor Authorization**

* **Child Abuse -**When I have reasonable cause to believe that a child has been subjected to abuse or neglect, or if I observe a child being subjected to conditions which would reasonably result in abuse or neglect, I must report this to the proper law enforcement agency or to the Nebraska Department of Health and Human Services.
* **Adult and Domestic Abuse -** When I have reasonable cause to believe that an adult has been subjected to abuse or neglect, or if I observe an adult being subjected to conditions which would reasonably result in abuse or neglect, I must report this to the proper law enforcement agency or to the Nebraska Department of Health and Human Services.
* ***“Vulnerable adult”-***shall mean any person eighteen years of age or older who has a substantial mental or functional impairment or for whom a guardian has been appointed under the Nebraska Probate Code.
* **Health Oversight Activities -**For the purpose of any investigation, the Director of Health and Human Services or the Director of Regulations and Licensure (the board of licenses me to practice) may subpoena relevant records from me.
* **Judicial and Administrative Proceedings-** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization from you or your personal or legally-appointed representative, or a court order. This privilege **does not apply** when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.
* **Serious Threat to Health or Safety (of yourself or others) –** If you communicate to me a serious threat of physical violence against a reasonably identifiable victim or victims, I must communicate such threat to the victim or victims and to a law enforcement agency.
* **Worker’s Compensation -** If you file a worker’s compensation claim, I must, on demand, make available records relevant to that claim to your employer, the insurance carrier, the worker’s compensation court, and to you.

1. **Patient’s Rights and Therapist’s Duties**

**Patient Rights:**

* **Right to Request Restrictions –** You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction of your request.
* **Right to Receive Confidential Communications 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 I can submit your bills to another location.)
* **Right to Inspect and Copy –** You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you; as long as the PHI is maintained in the record. I may deny your access to your PHI under certain circumstances, but in some cases, you may have this decision reviewed. Upon your request, I will discuss with you the details of the request and denial process.
* **Right to Amend –** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
* **Right to an Accounting –** You generally have the right to receive an accounting of disclosure of PHI for which you have neither provided consent nor authorization (as described in Section III of this notice). On your request, I will discuss with you the details of the accounting process.
* **Right to a 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 notice electronically.

**Therapist’s Duties:**

* I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with request to PHI.
* I reserve the right to change this privacy policy and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
* If I revise my policies and procedures, I will either hand deliver or mail to you the new revisions.

1. **Complaints:**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me Deb Perrin at 4535 Normal Blvd, STE 142, Lincoln, Ne 68506.

You also have a right to send a written complaint to the Secretary of the U.S. Department of Health and Human Services

1. **Effective Date Restrictions and Changes to Privacy Policy:**

This notice will go into effect on January 22, 2019.

I will limit the uses or disclosures of your PHI that I have made in good faith, If I believe such disclosure will be physically or emotionally harmful to you, I will deny your request; with exception of disclosures required by law.



RECEIPT OF NOTICE OF INFORMATION PRIVACY PRACTICES

Name of Individual Receiving Services

The signature below indicates that I have received or been offered a copy of the Health Information Portability and Accountability Act (HIPPA) 1996 and “Notice of Information Privacy Practices”

Patient/Guarantor Signature Date

If signing for a minor child/children, list the name of the child or children below: