**NOTICE OF PRIVACY PRACTICES**

The HIPAA (Health Insurance Portability and Accountability Act of 1996) requires all health care records and individually identifiable health information used or disclosed to me in any form, whether electronically, paper, or verbally transmitted, to be kept confidential.

This federal law gives you, the client, significant (not necessarily new) rights to understand and to control how your health information is used. HIPAA penalizes those covered entities that misuse such information. As required by HIPAA, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may disclose it.

Without specific written authorization (as in the Release of Information form), I am permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations only as outlined below.

This notice describes how medical information about you may and may not be used and disclosed, and how you can get access to this information.  It also contains guidelines for e-mail communications between us. Please review it carefully.

I respect your privacy.  I understand that your personal health information is very sensitive.  I will not disclose your information to others unless you authorize it, or unless the law authorizes or requires me to do so.

This notice of privacy practices relates to both written and verbal material.  Any social service, insurance, billing service, or managed care company with whom I do business is also subject to confidentiality practices.

**EXAMPLES OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

**For treatment:**I collect various types of personal information from you to assist in diagnosis, treatment planning, recordkeeping, and billing.

I may also provide information, with your consent, to others providing care to you, such as your family doctor or other health care provider, to ensure the best treatment for you.

**For payment:** Health plans need information from me about your care, if you are using insurance.  Information provided to insurance plans may include your diagnosis, procedure performed, rendered, or recommended care.

**For health care operations:** I may contact you about your appointments or other health-related services.In addition,I may be asked by your insurance company to review your record for audit.

**DEFINITION OF TERMS**

**Treatment** means providing, coordinating, or managing health care and related serviced by one or more health care providers. Examples: letting another provider know that I am referring you to him or her, or vice versa, with your knowledge.

A receptionist in the office or a billing agent (should I decide to employ either or both) may know limited information as to your name, address, date of birth, insurance ID number (which may also be your social security number), diagnosis code, as well as the payer’s information if it is someone other than yourself. A consultant may know about your case in general terms, without your name or other identifying information.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities to you or the financially responsible party, and utilization review by the insurance company providing coverage for your mental health services. If I use a billing agent, he or she also would be aware of such details.

**Health Care Operations** include the business aspects of running my practice. This could include a support staff person’s knowledge of name, dates of service, and payments if I should employ such a person.

Unless you indicate otherwise, no information about your coming to appointments here, or the content of any such appointments or telephone calls between us, will be shared with any other person except as stated above. If you wish any information to be shared (with another counselor, physician or other healthcare provider, family member, etc.), you must sign a Release of Information form specifying what information I may share and to whom and for how long (not beyond 90 days). You may revoke the Release of Information at any time, in writing, and I must abide by that request, except to the extent that I had already taken action authorized by it, prior to that time.

**YOUR HEALTH INFORMATION RIGHTS**

The health and billing records that are part of your treatment and are stored by me are the property of this office.  The protected health information in it, however, generally belongs to you.  You have a right to:

Receive, read, and ask questions about this notice.

Ask me to restrict uses and disclosures in writing to the extent is permitted by law.

Request that you be allowed to see and get a copy of your protected health information.  You must make this request in writing.  A fee is charged for more than one such request in a year.

Ask me to change or correct any health information.  You must make this request in writing.  You may write a statement of disagreement if your request is denied.  It will be stored in your record and included in any authorized release of your records.

Cancel prior authorizations to use or disclose information by giving written revocation, as indicated above.

**MY RESPONSIBILITY**

I am required to:

* Keep your protected health information private.
* Give you this notice.
* Follow the terms of this notice.

I have the right to make adjustments to my privacy practices within the limits of the law as necessary to improve efficiency and/or clarity.  If I make changes, I will update this notice and inform you.  You may ask for the updated notice at any time.

**TO ASK FOR HELP OR COMPLAIN**

If you have general questions, or you want to report a problem about the handling of your information, please contact me.  If you feel that your privacy rights have been violated, you may file a written complaint with the U.S. Secretary of Health and Human Services at (http://www.dhhs.gov/ocr/privacyhowtofile.htm).

**OTHER DISCLOSURES AND USES OF PROTECTED HEALTH INFORMATION**

I may give limited “need-to-know” information to someone who helps pay for your care to support continuation of care.  You have the right to object to such disclosure.  This objection needs to be submitted in writing.  Your participation with an insurer is your consent for that insurer to have access to certain protected health information for the purposes of authorizing medically necessary treatment.

**I MAY USE AND DISCLOSE YOUR INFORMATION WITHOUT YOUR AUTHORIZATION:**

* To report suspected abuse or neglect of a child, dependent adult, or developmentally disabled person to authorities, as required by law.
* To correctional institutions if you are in jail, as necessary for your health and the health and safety of others.
* To law enforcement or the courts when I receive a subpoena or court order.
* To social service agencies or law enforcement to prevent serious harm to you or others, as required by law.
* To comply with Public Health laws.

**GUIDELINES FOR USING EMAIL**

I offer clients the opportunity to communicate by email. **In general, transmitting client information by email, however, has a number of risks that clients should consider before using email.** As you may know, these include, but are not limited to, the following:

* Email can be circulated, forwarded, and stored in numerous paper and electronic files.
* Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
* Email senders can easily misaddress an email
* Email is easier to falsify than handwritten or signed documents.
* Backup copies of email may exist even after the sender or the recipient has “deleted.” Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
* Email can be intercepted, altered, forwarded, or used without authorization or detection.
* Email can be used to introduce viruses into computer systems.
* Email can be used as evidence in court.

I will use reasonable means to protect the security and confidentiality of email information to be sent and received. However, because of the risks outlined above:

**I cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by my intentional misconduct**. Thus, you must consent to the use of email for client information.

Consent to the use of email includes agreement with the following conditions:

Emails may be forwarded securely but only as may be necessary for diagnosis, treatment, or reimbursement. **I will not forward emails to independent third parties without your prior written consent, except as authorized or required by law**.

Although I make every effort to read and respond promptly to email, I cannot guarantee that any particular email from you will be read and responded to within any defined period of time. Thus **you agree not use email for emergencies, crises, or other time-sensitive matters**.

If your email requires or invites a response from me, and you have not received a response within a reasonable time period, **it is your responsibility to follow up to determine whether the I, the intended recipient, received the message.**

**You should not use email for communication regarding sensitive information unless both parties use encryption.**

You are responsible for informing me of any types of information you do not want sent by email.

You are responsible for protecting your password or other means of access to email. I may not be held liable for breaches of confidentiality caused by you or any third party.

It is your responsibility to follow up and/or schedule an appointment if warranted.