HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)

When you visit us, a record is made of your child's symptoms, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of the mental health provider. The information within belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosures to others. In using and disclosing your PHI, it is our objective to follow the 1996 Privacy Standards of the Federal Health Portability and Accountability Act (HIPAA) and a requirement of state law.

Your Mental Health Record Serves as:

- A basis for planning your care and treatment.
- A means of communication among the health professionals who may contribute to your care.
- A legal document describing the care you received.
- A means by which you or a third-party payer can verify that services billed were actually provided.
- A source of data for facility planning.
- A tool with which we can access and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of Hope Within Healing Counseling Services, PLLC:

We are required to:

- Maintain the privacy of your PHI as required by law and provide you with notice of legal duties and privacy practices with respect to the PHI that we collect and maintain about you.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our practices change, we will post new changes in the reception room and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights

You have the right to:

- Review and obtain a paper copy of the notice of information practices and your health information upon request. A few exceptions apply. Copy charges may apply.
- Request and provide written authorization and permission to release PHI for purposes of outside treatment and health care. This authorization excludes psychotherapy notes and any audio or video tapes that may have been made with your permission for training purposes.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
- Request a restriction on certain uses and disclosures of PHI, but we are not required to agree to the restriction request. You should address your restriction in writing to the Privacy Officer by asking for the name of the Privacy Officer, address, and phone. We will notify you within 10 days if we cannot agree to the restriction.
- Request that we amend your health information by submitting a written request with reasons supporting the request to the Privacy Officer. We are not required to agree with the requested amendment.
- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations, and certain activities in the past six years or prior to 4/14/03.
- Request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment, and Health Operations:

Hope within Healing Counseling Services, PLLC will use your PHI, with your consent, in the following circumstances:

Treatment: Information obtained by a therapist will be recorded in your client file and used to determine the management and coordination of treatment that will be provided for you.

Disclosure to others outside of this agency: I may have the need to consult other therapists or professionals about certain aspects of your case in order to provide high quality treatment. If you give us written authorization, you may revoke it in writing at any time but that revocation will not affect any use or disclosures permitted by your authorization while it is in effect. We will not use or disclose your health information without your authorization, except to report serious threats to the health or safety of you, a child and/or vulnerable adult. This includes suspicion of child abuse/neglect, elder abuse, and threats of harm toward you or others.

For payment, if applicable: We may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.

For health care operations: Members of the mental health staff may use information in your health record to assess the performance and operations of our services. This information will be used in an effort to continually improve the quality and effectiveness of the mental health care and services I provide.

We may use or disclose your PHI in the following situations **without** your authorization:

- **As required by law**
- **Communicable diseases (Public Health)**
- **Abuse/Neglect**
- **Legal Proceedings**
- **Law Enforcement**
- **Workers' compensation**
- **Deceased Persons**
- **Emergencies**
- **Intent or Threat to harm/hurt self**
- **Public Safety (Duty to Warn)**

Under the law, we must make disclosures to you when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
1-877-696-6774.

HIPAA Privacy Authorization for Use and Disclosure of Personal Mental Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time. You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read and understand the HIPAA Privacy Notice of Hope within Healing Counseling Services, PLLC containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Client/Guardian Name: _____
Last First MI

Client Name (if different than above): _____
Last First MI

Address: _____
Street City State Zip

Date of Birth: _____ Date: _____

Client/Guardian Signature: _____

For office use only

I have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained.

Reason: _____

_____ _____
Clinician Signature Date

_____
Individual HIPAA Provider Number of Clinician Completing Form

HIPAA Organization Number or Clinician Completing Form:_____