



# CENTER FOR INTEGRATIVE PSYCHOTHERAPY

## **This Notice Describes How Health Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.**

We understand that information about you and your health is very personal. Therefore, we strive to protect your privacy as required by law. We will only use and disclose your personal health information (“PHI”) as allowed by law. We train our staff and work force to be sensitive about privacy and to respect the confidentiality of your PHI.

We are required by law to maintain the privacy of our patients’ PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice, so long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new notice effective for all PHI maintained by us.

### **USES AND DISCLOSURES OF YOUR PHI**

The following categories describe the ways we may use or disclose your PHI without your consent or authorization. For each category, we will give you illustrative examples.

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

*Treatment:* We use and disclose your PHI as necessary for your treatment. For instance, Practicum Students, Interns, Residents and other professionals involved in your care – within our practice – may use information in your medical record that may include history, procedures, tests, etc. to plan a course of treatment for you.

*Payment:* We use and disclose your PHI as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. Also, we may use your information to prepare a bill to send to you or to the person responsible for your payment.

*Health Care Operations:* We use and disclose your PHI for health care operations. This is necessary to operate Center for Integrative Psychotherapy, including by ensuring that our patients receive high quality care and that our health care professionals receive superior training. For example, we may use your PHI to conduct an evaluation of the treatment and services we provide, or to review the performance of our staff. Your health information may also be disclosed to our Director, Clinicians, Practicum Students, Interns and Residents for education and training purposes.

The sharing of your PHI for treatment payment, and health care operations may happen electronically. Electronic communications enable fast, secure access to your information for those participating in and coordinating your care to improve the overall quality of your health and prevent delays in treatment.

**Persons Involved In Your Care.** Unless you object, we may, in our professional judgment, disclose your PHI to a member of your family, a close friend, or any person you identify, to

facilitate that person’s involvement in caring for you or in payment for your care. We may use or disclose your PHI to assist in notifying a family member, personal representative or any person responsible for your care of your location and general condition. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts to locate a family member or other persons who may be involved in some aspect of caring for you.

**Appointments and Services.** We may use your PHI to remind you about appointments, if you sign up for appointment reminders through e-mail.

**Research.** We may use and disclose your PHI, including PHI generated for use in a research study, as permitted by law for research, subject to your explicit authorization and/or oversight by Center for Integrative Psychotherapy Review Board (IRB), committees charged with protecting the privacy rights and safety of human subject research, or a similar committee. In all cases where your specific authorization has not been obtained, your privacy will be protected by confidentiality requirements evaluated by such a committee. For example, the IRB may approve the use of your health information with only limited identifying information to conduct outcomes research to see if a particular procedure is effective. Center for Integrative Psychotherapy supports research and may invite you to participate in certain research activities.

**Business Associates.** We may contract with certain outside persons or organizations to perform certain services on our behalf, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations. In such cases, we require these business associates, and any of their subcontractors, to appropriately safeguard the privacy of your information.

**Other Uses and Disclosures.** We are permitted or required by law to make certain other uses and disclosures of your PHI without your consent or authorization. Subject to conditions specified by law, we may release your PHI:

- for any purpose required by law;
- to certain governmental agencies if we suspect child abuse or neglect, or if we believe you to be a victim of abuse, neglect, or domestic violence;
- to your employer when we have provided health care to you at the request of your employer for purposes related to occupational health and safety. In most cases you will receive notice that your PHI is being disclosed to your employer;
- if required by law to a government oversight agency conducting audits, investigations, inspections, and related oversight functions;
- in emergency circumstances, such as to prevent a serious and imminent threat to a person or the public;
- if required to do so by a court or administrative order, subpoena, or discovery request. In most cases you will have notice of such release;
- to law enforcement officials, including for purposes of identifying or locating suspects, fugitives, witnesses, or

victims of crime, or for other allowable law enforcement purposes; 45 CFR §164.512 (f) (2)

**Your Authorization.** Except as outlined above, we will not use or disclose your PHI for any other purpose unless you have signed a form authorizing the use or disclosure. The form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke your authorization in writing, except to the extent we have already relied upon it. These situations can include:

- uses and disclosures of progress and psychotherapy notes;
- uses and disclosures of PHI specially protected by state and/or Federal law and regulations;
- uses and disclosures for certain research protocols;

**Confidentiality of Alcohol and Drug Abuse Patient Records, HIV-Related Information, and Mental Health Records.** The confidentiality of alcohol and drug abuse treatment records, HIV-related information, and mental health records maintained by us is specifically protected by state and/or Federal law and regulations. Generally, we may not disclose such information unless you consent in writing, the disclosure is allowed by a court order, or in limited and regulated other circumstances.

**RIGHTS THAT YOU HAVE**

**Access to Your PHI.** Generally, you have the right to access, inspect, and/or receive paper copies of certain PHI that we maintain about you.

Requests for access must be made in writing and be signed by you or, when applicable, your personal representative. We will charge you for a copy of your medical records in accordance with a schedule of fees under federal and state law.

**Amendments to Your PHI.** You have the right to request that PHI that we maintain about you be amended or corrected.

Requests for amendment must be made in writing and signed by you or, when applicable, your personal representative and must state the reasons for the amendment/correction request. We are not obligated to make all requested amendments but will give each request careful consideration. If we grant your amendment request, we may also reach out to other prior recipients of your information to inform them of the change.

Please note that even if we grant your request, we may not delete information already documented in your medical record.

**Restrictions on Disclosures to Health Plans.** You have the right to request a restriction on certain disclosures of your PHI to your health plan. We are required to honor such requests for restrictions only when you or someone on your behalf, other than your health plan, pays for the health care item(s) or service(s) in full.

Such requests must be made in writing and signed by you and, when applicable, your personal representative.

**Confidential Communications.** You have the right to request communications regarding your PHI from us by alternative means and we will accommodate reasonable requests by you. You, or when applicable, your personal representative must request such confidential communication in writing.

**Breach Notification.** We are required to notify you in writing of any breach of your unsecured PHI without unreasonable delay, but in any event, no later than 60 days after we discover the breach.

**Paper Copy of Notice.** As a patient, you have the right to obtain a paper copy of this Notice. You can also find this Notice on our website at: <https://cip-cbt.com/forms>

**ADDITIONAL INFORMATION**

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint in writing to Center for Integrative Psychotherapy. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, DC. All complaints must be made in writing and in no way will affect the quality of care you receive from us.

**For Further Information.** If you have questions or need further assistance regarding this notice, you may contact Center for Integrative Psychotherapy by telephone at (610) 432-5066 or by e-mail at [cipcbt@ptd.net](mailto:cipcbt@ptd.net)

**This Notice is effective May 1<sup>st</sup>, 2019**

**Your signature below is only to acknowledge that you have received this notice of our Privacy Practices.**

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_