**CALIFORNIA NOTICE FORM**

**Notice of Psychotherapists’ Policies and Practices to Protect the Privacy of Your Health**

**Information**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION

ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO

THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

I may *use* or *disclose* your *protected health information* (*PHI*), for certain *treatment, payment,*

*and health care operations* purposes without your *authorization*. In certain circumstances I can

only do so when the person or business requesting your PHI gives me a written request that

includes certain promises regarding protecting the confidentiality of your PHI. To help clarify

these terms, here are some definitions:

* “*PHI”* refers to information in your health record that could identify you.
* *“Treatment and Payment Operations”*
	+ *Treatment* is when I provide or another healthcare provider diagnoses or treats you. An

example of treatment would be when I consult with another health care provider, such as

your family physician or another psychologist, regarding your treatment.

- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are

when I disclose your PHI to your health insurer to obtain reimbursement for your health

care or to determine eligibility or coverage.

*- Health Care Operations* is when I disclose your PHI to your health care service plan

(for example your health insurer), or to your other health care providers contracting with

your plan, for administering the plan, such as 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.

* “*Disclosure*” applies to activities outside of my office such as releasing, transferring, or

providing access to information about you to other parties.

* *“Authorization”* means written permission for specific uses or disclosures.
1. **Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations

when your appropriate authorization is obtained. In those instances when I am asked for

information for purposes outside of treatment and payment operations, I will obtain an

authorization from you before releasing this information. I will also need to obtain an

authorization before releasing your psychotherapy notes. *“Psychotherapy notes”* are notes I have

made about our conversation during a private, group, joint, or family counseling session, which I

have kept separate from the rest of your medical record. These notes are given a greater degree

of protection than PHI.

You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time;

however, the revocation or modification is not effective until I receive it.

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

I may use or disclose PHI without your consent or authorization in the following circumstances:

* **Child Abuse:** Whenever I, in my professional capacity, have knowledge of or observe a child

I know or reasonably suspect, has been the victim of child abuse or neglect, I must

immediately report such to a police department or sheriff’s department, county probation

department, or county welfare department. Also, if I have knowledge of or reasonably

suspect that mental suffering has been inflicted upon a child or that his or her emotional wellbeing is endangered in any other way, I may report such to the above agencies.

* **Adult and Domestic Abuse:** If I, in my professional capacity, have observed or have

knowledge of an incident that reasonably appears to be physical abuse, abandonment,

abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told

by an elder or dependent adult that he or she has experienced these or if I reasonably suspect

such, I must report the known or suspected abuse immediately to the local ombudsman or the

local law enforcement agency.

I do not have to report such an incident if:

* 1. I have been told by an elder or dependent adult that he or she has experienced behavior

constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;

2) I am not aware of any independent evidence that corroborates the statement that the

abuse has occurred;

3) the elder or dependent adult has been diagnosed with a mental illness or dementia, or

is the subject of a court-ordered conservatorship because of a mental illness or dementia;

4) in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

* **Health Oversight:** If a complaint is filed against me with the California Board of

Psychology, the Board has the authority to subpoena confidential mental health

information from me relevant to that complaint.

* **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and

a request is made about the professional services that I have provided you, I must not

release your information without 1) your written authorization or the authorization of

your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum

(a subpoena to produce records) where the party seeking your records provides me with a

showing that you or your attorney have been served with a copy of the subpoena,

affidavit and the appropriate notice, and you have not notified me that you are bringing a

motion in the court to quash (block) or modify the subpoena. The privilege does not

apply when you are being evaluated for a third party or where the evaluation is courtordered.

I will inform you in advance if this is the case.

* **Serious Threat to Health or Safety:** If you communicate to me a serious threat of

physical violence against an identifiable victim, I must make reasonable efforts to

communicate that information to the potential victim and the police. If I have reasonable

cause to believe that you are in such a condition, as to be dangerous to yourself or others,

I may release relevant information as necessary to prevent the threatened danger.

* **Workers’ Compensation**: If you file a worker's compensation claim, I must furnish a

report to your employer, incorporating my findings about your injury and treatment,

within five working days from the date of the your initial examination, and at subsequent

intervals as may be required by the administrative director of the Worker’s Compensation

Commission in order to determine your eligibility for worker’s compensation.

1. **Patient's Rights and Psychologist's Duties**

Patient’s Rights:

* *Right to Request Restrictions* –You have the right to request restrictions on certain uses

and disclosures of protected health information about you. However, I am not required to

agree to a restriction you 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 will send your bills

to another address.)

* *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of

PHI in my mental health and billing records used to make decisions about you for as long

as the PHI is maintained in the record. I may deny your access to PHI under certain

circumstances, but in some cases you may have this decision reviewed. On 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

disclosures 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.

Psychotherapist’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 respect to PHI.

* I reserve the right to change the privacy policies 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 notify you in writing and give you a copy of the
* new policies at our next session.

**V. 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 at: Terry Binkovitz, PhD. 310 826-9100

You may also send a written complaint to the Secretary of the U.S. Department of Health and

Human Services. The person listed above can provide you with the appropriate address upon

request.

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

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions

effective for all PHI that I maintain. I will provide you with a revised notice in writing by mail or

at our next session.

I acknowledge receipt of this notice.

Patient Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_