Finding HOPE

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Notice of Privacy Practices & HIPAA Privacy Authorization Form

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION, REQUIRED BY THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT, 45 C.F.R. PARTS 160 & 164. THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my client, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing a general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. Limits of Confidentiality

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization.

There are some important exceptions to this rule of confidentiality. If you wish to receive mental health services from me, you must sign this form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in a life-threatening emergency during one of our sessions or when I am in communication with you, I will contact emergency services as well as your emergency contact that you have provided to inform them of your situation.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Maryland law to report the matter immediately to the applicable of Department of Social Services.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Maryland law to immediately make a report and provide relevant information to the applicable Maryland Adult protective service agency.

· Health Oversight: If the Maryland Board of Social Work Examiners investigates my private practice, I may be required to disclose private health information to the Board.

· Law Enforcement and Court Proceedings: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

· Serious Threat to Health or Safety: Under Maryland law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause yourself serious bodily injury or death, or communicate threats to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect you and/or the third parties. These precautions may include 1) notifying a law enforcement officer and/or completing an emergency petition for a psychiatric evaluation, which could lead to psychiatric hospitalization or 2) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under age 18.

· Workers Compensation: If I am treating you for Worker's Compensation purposes, I must provide periodic progress reports, treatment records, and bills upon request to you, the Maryland Office of Hearings and Adjudication, your employer, or your insurer, or their representatives.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Client's Rights and Provider's Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· 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 not contact you at your home number. You may also request that I only contact you via cell, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – 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 written request, I will discuss with you the details of the accounting process.

· Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you additional copies of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date . A new copy will be given to you. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

Client's Acknowledgement of Receipt of Notice of Privacy Practices – Effective Date: _____

I have been provided a copy of Finding Hope's Notice of Privacy Practices. We have discussed these policies, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

Date: _____

Description of Personal Representative Authority: _____