



Stonewater Therapy, LLC

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, and how you can access your own information. Please review it carefully.

Stonewater Therapy, LLC is committed to maintaining the privacy of your health information. The privacy practices stated below are the minimum standards of privacy that apply to all healthcare providers. I understand that health information about you and your health care is personal, and I am committed to protecting your health information. A record of the care and services you receive will be created. This record is needed to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this mental health care practice. This notice explains how health information may be used and disclosed. It also describes your rights to the health information kept about you and describes certain obligations we have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

YOUR HEALTH INFORMATION

I may use and disclose health information about you, only with your signed written authorization, except in those situations listed below. I must obtain your written authorization to use and disclose mental health, HIV, and alcohol and other drug treatment records. The authorization states the recipient of the information, limitations on the information released, and the time period covered by the authorization. If you give authorization to use or disclose health information about you, you may cancel this authorization in writing at any time. However, I cannot take back any use or disclosure already made with your permission.

I may use and disclose health information about you, without your written authorization in the following ways:

- When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
- For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
- For health oversight activities, including audits and investigations.

- For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
- For law enforcement purposes, including reporting crimes occurring on my premises.
- To coroners or medical examiners, when such individuals are performing duties authorized by law.
- For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
- Specialized government functions, including ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or helping to ensure the safety of those working within or housed in correctional institutions.
- For workers' compensation purposes. Although my preference is to obtain authorization from you, I may disclose your PHI to comply with workers' compensation laws.
- Appointment reminders and health-related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to inform you about treatment alternatives, or other healthcare services or benefits that I offer.
- For payment purposes. I may provide your insurance company or health plan with information about a service so that the service can be authorized or for reimbursement purposes.
- For a serious threat to the health and safety of yourself or others. For example, I will notify parents or a significant other in the event of a suicide threat or threat to hurt others.
- To family members who are involved in your treatment or your child's treatment. For example, I may share treatment information with a parent or legal guardian of a child who is legally authorized to access this information.

You have the following rights regarding health information about you:

- The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
- The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
- The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
- The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

- The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
- The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
- The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on 8/21/25. Acknowledgement of Receipt of Privacy Notice
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I AGREE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.