Sunny M. Mueller, LPCC

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Notice of Privacy Practices - MINOR

When it comes to your health information, you have certain rights, choices, and responsibilities, as do I. This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully and feel free to ask me any questions that you may have.

The terms "you," and/or "your" indicate the adult client or in the case of a minor client, the client's authorizing party, whichever is applicable. The terms "I," "me," and/or "myself" refer to Sunny M. Mueller, LPCC.

By initialing each section, you are agreeing that you have read and understand the content contained therein.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
  - You may ask to see or get an electronic or paper copy of your medical record and other health information I have about you. Ask me how to do this.
  - I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.
- Correct your paper or electronic medical record
  - You may ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this.
  - I may say "no" to your request, but I will tell you why in writing within 60 days.
- Request confidential communication
  - You may ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
  - I will say "yes" to all reasonable requests.
- Ask me to limit the information I share
  - You may ask me not to use or share certain health information for treatment, payment, or our operations. I am not required to agree to your request, and I may say "no" if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you may ask me not to share that information for the purpose of payment or our operations with your health insurer. I will say "yes" unless a law requires me to share that information.
- Get a list of those with whom I have shared your information
  - You may ask for a list (accounting) of the times I have shared your health information for six years prior to the date you ask, who I shared it with, and why.
  - I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- Get a copy of this privacy notice
    - You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.
- Choose someone to act for you
    - If you have given someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information.
    - I will make sure the person has this authority and may act for you before I take any action.
- File a complaint if you believe your privacy rights have been violated
    - You may complain if you feel I have violated your rights by contacting me at:

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    - The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors. You may contact the board at:

      Board of Behavioural Sciences
      1625 North Market Blvd., Suite S200
      Sacramento, CA 95834
      916.574.7830
      www.bbs.ca.gov
    - You may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by contacting them at:

      U.S. Department of Health and Human Services Office for Civil Rights
      200 Independence Avenue, S.W.
      Washington, D.C. 20201
      877.696.6775
      www.hhs.gov
    - I will not retaliate against you for filing a complaint.

INITIAL: _____

Your Choices

You have some choices in the way that I use and share information as I:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market services, sell your information, raise funds

For certain health information, you may tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, talk to me. Tell me what you want me to do, and I will follow your instructions.

- In the following cases, you have both the right and choice to tell me to:
    - Share information with your family, close friends, or others involved in your care
    - Share information in a disaster relief situation
    - Include your information in a hospital directory

If you are not able to tell me your preference, for example, if you are unconscious, I may go ahead and share your information if it is in your best interest. I may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In the following cases, I will never share your information unless you give me written permission:
    - Marketing purposes
    - Sale of your information
    - Most sharing of psychotherapy notes
- In the case of fundraising:
    - I may contact you for fundraising efforts, but you may tell me not to contact you again.

INITIAL: _____

My Uses and Disclosures

I may use and share your information as I:

- Treat you
    - I may use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- Run my business
    - I may use and share your health information to run my practice, improve your care, and contact you when necessary. *Example: I use health information about you to manage your treatment and services.*
- Bill for my services
    - I may use and share your health information to bill and get payment from health plans or other entities. *Example: I give information about you to your health insurance plan so it will pay for your services.*
- Help with public health and safety issues
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- Do research
    - I may use or share your information for health research.
- Comply with the law
    - I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I am complying with federal privacy law.
- Respond to organ and tissue donation requests
    - I may share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
    - I may share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
  - I may share health information about you in response to a court or administrative order, or in response to a subpoena.

How else may I use or share your health information?

I am allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. I must meet many conditions in the law before I may share your information for these purposes. For more information, see: https://www.hhs.gov/hipaa/for-individuals/index.html.

INITIAL: _____

My Responsibilities

- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I will follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me I may do so in writing. If you tell me I may, you may change your mind at any time. Let me know in writing if you change your mind.

For more information, see: https://www.hhs.gov/hipaa/for-individuals/index.html.

INITIAL: _____

Changes to the Terms of this Notice

The effective date of this notice is January 02, 2024. I may change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request.

_____

Client (PRINT)

_____

*Client (SIGNATURE)** DATE*

**ONLY if minor client is aged 12-17 years seeking independent therapy*

_____

Authorizing Party (PRINT)

Reason for Authorizing Representation:
☐ Client is a minor
☐ Client is deceased
☐ Other: _____

Type of Authorizing Representation:
☐ Parent with sole legal and/or physical custody*
☐ Parent with joint legal and/or physical custody*
☐ Legal Guardian*
☐ Estate Representative*
☐ Other: _____

* You may be required to provide documentation validating this status*

_____

Authorizing Party (SIGNATURE) DATE