

**BRIAR ROSE CENTER: THE HOME OF HOPE & HEALING, P.L.L.C.**  
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**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this Privacy Notice, please contact Kimberly Cole, Psy.D. at (509) 473-9157.

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Briar Rose Center: The Home of Hope & Healing is committed to protecting your health information and privacy. In this Notice of Privacy Practices, I describe:

- My obligations are to protect your health information;
- How your protected health information may be used or disclosed to others for treatment, payment or health care operations;
- Other purposes that are permitted or required by law;
- Your rights regarding health information I maintain about you, and;
- A brief description of how you may exercise these rights.

“Protected health information” means health information (including identifying information about you) I have collected from you or received from your health care providers, health plans, your employer, or a health care clearinghouse. It may include information about your past, present or future physical or mental health condition, the provision of your health care, and payment for your health care services.

I am obligated to comply with the terms of our current Notice of Privacy Practices.

This notice applies to Briar Rose Center: The Home of Hope & Healing, PLLC.

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**WHAT LAWS PROTECT MY HEALTH INFORMATION?**

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets the minimum standards. Washington State laws for mental health care are, in most instances, stricter than the federal rules (based on WAC 388-865-0435, 388-865-0436, 388-865-0440, 388-862-360; RCW 70.02, 71.05, 71.34, 18.19, 70.24, 71.12, 13.50, and 26.44).

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**WHO WILL SEE MY HEALTH INFORMATION?**

I will use and disclose your health information as described in each category listed below. When I disclose this information it will only be the minimum necessary to serve your healthcare needs. For each category, I will explain what I mean in an example.

**For Treatment.** I will use and disclose your health information to provide, coordinate and manage your health care and any related services. For example, I may need to disclose information to a case manager, physician, or other professional who is responsible for coordinating your care.

**For Payment.** I may use or disclose your health information so that the treatment and services you receive are approved, billed to, and payment is collected from your health plan or other third party payer. For example, your health plan may ask for your health information to determine if the plan will approve additional visits to your therapist.

**For Health Care Operations.** I may use and disclose health information about you for my healthcare operations. These uses and disclosures are necessary to run this organization and make sure that my clients receive quality care. These activities may include:

- evaluation of the performance of Center staff;
- assessment of the quality of care and outcomes in your case and similar cases;
- efforts to improve our facilities and services; and
- efforts to improvement of the quality and effectiveness of the healthcare I provide

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**WHEN WILL BRIAR ROSE CENTER: THE HOME OF HOPE & HEALING, PLLC ASK PERMISSION TO SHARE MY INFORMATION?**

I will ask you to sign a CONSENT TO RECEIVE SERVICES form and a CLIENT AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION form.

You may revoke an authorization at any time. If you revoke your authorization I will not make any further uses or disclosures of your health information under that authorization, unless I have already taken an action relying upon your previous authorization.

I will request your permission to disclose your health information to another health care provider (e.g., your primary care physician or a laboratory) working outside of Briar Rose Center for purposes of your treatment.

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**WHEN WILL BRIAR ROSE CENTER: THE HOME OF HOPE & HEALING DISCLOSE MY HEALTH INFORMATION WITHOUT MY PERMISSION?**

**Persons Involved in Your Care.** I may provide health information about you to someone who helps pay for your care. I may use or disclose your health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

In limited circumstances, I may disclose health information about you to a friend or family member who is involved in your care. However, if you are physically present and capable of making health care decisions, your health information may only be disclosed with your agreement to persons you designate.

In an emergency, I may disclose your health information to a spouse, family member, or friend so that person may assist in your care. In this case I will determine whether the disclosure is in your best interest and, if so, only disclose information that is directly relevant to participation in your care.

If you are unable to make health care decisions, I will disclose your health information to: a person designated to participate in your care by a valid advance directive; your guardian or other person appointed by a court; or if applicable, a state agency responsible for consenting to your care.

**Emergencies.** I may use and disclose your health information in an emergency treatment situation. For example, I may provide your health information to a paramedic who is transporting you in an ambulance. If a clinician is required by law to treat you and your treating clinician has been unable to obtain your authorization, the treating clinician may nevertheless use or disclose your health information to treat you.

**As Required By Law.** I will disclose health information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** I may use and disclose health information about you to prevent a serious and imminent threat to your health or safety; to the health or safety of the public; or to another person. Under these circumstances, I will only disclose health information to someone who is able to help prevent or lessen the threat.

**Public Health Activities.** I may disclose health information about you without your consent for public health activities including, for example, disclosures to:

- Report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
- Report vital events such as birth or death;
- Conduct public health surveillance or investigations;
- Report child abuse or neglect;
- Report certain events to the Food and Drug Administration (FDA) including information about defective products or problems with medications;
- Notify a person who may have been exposed or is at risk of contracting or spreading a communicable disease or condition;
- Notify the appropriate government agency if I believe you have been a victim of abuse, neglect or domestic violence, or if I am required or authorized by law to report such abuse, neglect or domestic violence.

**Health Oversight Activities.** I may disclose your health information to a health oversight agency for activities authorized by law. These include government agencies that oversee the health care system such as Medicare or Medicaid, or other government programs regulating health care and civil rights laws.

**Disclosures in Legal Proceedings.** I may disclose health information about you to a court or administrative agency when a judge or administrative agency orders us to do so. I also may disclose health information about you in legal proceedings without your permission or without a judge or administrative agency's order when I receive a court order for your health information. An attorney seeking health information must give at least 14 days advance notice to you and to us, giving an opportunity to seek a protective order.

**Law Enforcement Activities.** I may disclose health information to a law enforcement official for law enforcement purposes when:

- A court order, subpoena, warrant, summons or similar process requires us to do so; or
- The information is needed to identify or locate a suspect, fugitive, material witness or missing person; or
- I report a death that I believe may be the result of criminal conduct; or
- I report criminal conduct occurring on the premises of our facility; or
- I determine that the law enforcement purpose is to respond to a threat of an imminently dangerous activity by you against yourself or another person; or the disclosure is otherwise required by law.

**Crime Victims.** I may also disclose health information about a client who is a victim of a crime, without a court order or without being required to do so by law. However, I will do so only if the disclosure has been

requested by law enforcement official and the victim agrees to the disclosure or, in the case of the victim's incapacity, the following occurs:

- The law enforcement official represents to us that (i) the victim is not the subject of the investigation and (ii) an immediate law enforcement activity to prevent serious danger to the victim or others depends upon the disclosure; and
- I determine that the disclosure is in the victim's best interest.

**Medical Examiners.** I may provide health information about our clients to a medical examiner.

**Military and Veterans.** If you are a member of the armed forces, I may disclose your health information as required by military command authorities.

**National Security and Protective Services for the President and Others.** I may disclose medical information about you to authorized federal officials for national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may disclose health information about you to the correctional institution or law enforcement official.

**Workers' Compensation.** I may disclose health information about you to comply with the state's Workers' Compensation Law.

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**MAY I PUT LIMITS ON SHARING MY INFORMATION?**

You may request a restriction on the health information I use or disclose. You must request the restriction in writing on the CLIENT AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION.

I am not required to agree to a restriction that you may request. If I do agree, I will honor your request unless the restricted health information is needed to provide you with emergency treatment.

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**MAY I SEE AND HAVE A COPY OF MY INFORMATION?**

You have the right to receive a copy of your health information used to make decisions about your care. Usually, this would include clinical and billing records. I will provide you with a copy of the information at our premises. If you wish to receive the information in another format or location, you will need to make the request in writing.

You should give your request to our Privacy Officer or a case manager on a CLIENT AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION form.

I may deny your request to inspect or copy your health information in certain limited circumstances. The denial will be reviewed by a licensed health care professional not directly involved in the original decision. I will honor the final decision made by the reviewing licensed health care professional.

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**DO YOU KEEP A RECORD OF WHO YOU GIVE MY INFORMATION TO?**

You have the right to request an accounting of disclosures I have made of your health information. An accounting is a list of disclosures. But this list will not include certain disclosures of your health information, by way of example, those I have made for purposes of treatment, payment, and health care operations.

To request a record of disclosures, you must submit your request in writing to the Privacy Officer. The request should state the time period for which you wish to receive an accounting. This time period should not be longer than six years and not include dates before April 14, 2003.

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**MAY I CHANGE MY RECORDS?**

You have the right to request an amendment any health information used to make decisions about your care – usually, this would include clinical and billing records.

You must submit a written document to Kimberly Cole, Psy.D. or Susan Van Wormer, MSW, LMHC and tell me why you believe the information is incorrect or inaccurate.

I will deny your request if you ask us to amend health information that: was not created by us; is not part of the health information I maintain to make decisions about your care; is not part of the health information that you would be permitted to inspect or copy; or is accurate and complete.

You may then provide a written statement disagreeing with the denial. The requested amendment and our denial will be attached to all future disclosures of the health information subject of your request for amendment.

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**MAY I HAVE A COPY OF THIS NOTICE?**

I will post a copy of the current Notice at each site where I provide care and make copies available. You may also receive a copy by contacting Kimberly Cole, Psy.D. at (509) 473-9157 and requesting that one be mailed to you.

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**CAN YOU CHANGE YOUR PRIVACY PRACTICES?**

I may change the terms of our Notice of Privacy Practices to be effective for all health information I already have about you and any health information I receive in the future.

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**WHAT IF I BELIEVE MY PRIVACY RIGHTS HAVE BEEN VIOLATED?**

You can file a complaint with us in writing at the address on the front page of this notice. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

**I WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.**