



# Notice of Privacy Practices

TalkWorks Therapy, LLC

**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.**

This notice is effective as of January 1, 2021. I am required by applicable federal and state law to maintain the privacy of your health information and inform you of my privacy practices, legal obligations, and your rights concerning your health information. I must follow the privacy practices that are described in this notice (which may be amended occasionally). I am required to abide by the terms of the Notice of Privacy Practices that is most current. I reserve the right to change the terms of the notice at any time. Any changes will be effective for all protected health information that I maintain. The revised notice will be posted in the waiting room. You may request a copy of the revised notice at any time. I will answer your questions about my privacy practices and will ensure that I will comply with applicable laws and regulations. I can also take your complaints and share information about how to file a complaint.

## **I. Use And Disclosure Of Your Protected Health Information That May Be Made To Carry Out Healthcare Operations:**

I may use and disclose limited information from your record without your written authorization, excluding counseling notes as described in Section IV, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

**Treatment:** I may use and disclose limited information to provide treatment to you.

For example, I may use information to diagnose and provide counseling service to you. In addition, I may disclose information to other health care providers involved in your treatment.

**Payment:** I may use or disclose limited information from your record to obtain payment for the services you receive.

For example, I may submit your diagnosis with a health insurance claim to demonstrate to the insurer that the service should be covered.

**Health Care Operations:** I may use and disclose information from your record to allow health care operations including quality improvement activities, training programs, reviewing records to see how care can be improved, accreditation, certification, licensing or credentialing activities.

For example, I may use information in your record to train another counselor.



## **II. Your Individual Rights:**

**Right to Inspect and Copy:** You may request access to the information in your record maintained by TalkWorks Therapy, LLC to inspect and make a copy of it. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested.

**Right to Request Restrictions:** You may ask to restrict the use and disclosure of certain information in your record that would otherwise be allowed for treatment or payment. Requests for restrictions must be submitted in writing. I am not required to agree to any restriction you may request.

**Right to Accounting of Disclosures:** You have the right to request an accounting of any disclosures made by me.

**Right to Request Amendment:** If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

**Right to Obtain Notice:** You have the right to obtain a paper copy of this Notice upon request.

**Right to Complain:** You have the right to complain to us about our privacy. You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints. Except as described in this Notice, I may not make any use or disclosure of information from your record unless you give me your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was granted as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

## **III. Use Or Disclosure Of Your Protected Health Information That I Am Required To Make Without Your Permission:**

Communications between a counselor and client are privileged and may not be disclosed without your permission, except as required by law.

For example, counselors must report suspected abuse/neglect of a child, elder, or disabled person. I may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, to reduce the likelihood of harm to you or others.

Also, I must disclose information to the Department of Health and Human Services, if requested, to prove that I am complying with regulations that safeguard your health information.



I may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, I may disclose information in response to a subpoena or other legal process, even without a court order. You have the right to receive confidential communication from me.

For example, if you want to receive bills and other information at an alternative address, please notify me. I may contact you to provide information or appointment reminders as a courtesy. Please notify me if I should not leave a telephone message or use electronic communication. You are responsible for remembering your appointment, whether or not you receive a reminder. I may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

**IV. Uses And Disclosures Requiring Your Written Authorization:**

**Counseling Notes:** Notes recorded by your counselor documenting the contents of a counseling session with you. Counseling notes will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

**Marketing Communications:** I will not use your health information for marketing communications without your written authorization.

**V. Other Uses And Disclosures:**

Uses and disclosures other than those described in Section I & III above will only be made with your written authorization.

For example, you will need to sign an authorization form before I can send information to a school, or to your attorney. You may revoke any such authorization at any time.

**Consent for the Use or Disclosure of Health Information for Treatment, Payment, or Health Care Operations In our Notice of Privacy Practices:**

We provide you with information about how **TalkWorks Therapy, LLC** can use or disclose your mental health and medical information. As described in our Notice of Privacy Practices, we request your consent for any use or disclosure of mental health and medical information that is necessary to carry out treatment, payment, or health care operations.

You have a right to review our Notice of Privacy Practices before signing this Consent form.



## Notice of Privacy Practices Signature Page

Please keep the information and **return this page** to the receptionist.

This will be kept in your personal file for 7 years.

By signing this Consent form, you:

- 1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and
- 2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices. **You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed your health information in reliance upon this Consent.**

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client or Legal Representative