Katharine Campbell, PhD, LCSW
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Notice of Privacy Practices:
Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. This Agreement, which serves as the notice, explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where we are permitted or required to disclose information without either your consent or authorization. If such a situation arises, we limit disclosures to what is necessary. Reasons we may have to release your information without authorization:

1. Emergencies that arise such as an injury or illness that occurs at Inward Bound.
2. Judicial and administrative proceeding. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if we receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order us to disclose information.
3. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, we may be required to provide it for them.
4. If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
5. If a patient files a worker's compensation claim, and we are providing necessary treatment related to that claim, we must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
6. We may disclose the minimum necessary health information to business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

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There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment:

1. If we know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, we may be required to provide additional information.
2. If we know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that we file a report with the Florida Abuse Hotline. Once such a report is filed, we may be required to provide additional information.
3. If we believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, we may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient. This includes concerns of national security or public safety.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** We use and disclose your health information internally in the course of your treatment as well as within the process of clinical consultation with a clinical consultation group in which the therapist participates. If we wish to provide information outside of our practice or consultation group for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
- ***For Operations*** – We may use and disclose your health information within Inward Bound as part of our internal operations. For example, this could mean a review of records to assure quality or for training purposes. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

Patient's Rights:

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

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- ***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.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.
- ***Right to a copy of this notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, we will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with us at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with us in session before terminating or at least contact us by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not we think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise the policies and procedures, we will provide you with a revised notice in office during our session.

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COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact us, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW Washington, D.C. 20201 or by calling 202-619-0257. Inward Bound will not retaliate against you for filing a complaint.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE PRIVACY PRACTICES/ HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Katharine Campbell, PhD, LCSW Date

 Updated 12.28.17