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NOTICE OF PRIVACY PRACTICES

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

Introduction to Clients

This notice will tell you about how I handle information about you and your child. It tells how I use this information in my office, how I share it with other professionals and organizations, and how you can see it. I am required to tell you about this because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In most situations I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law or HIPAA. Clients who are 13 or older must sign the written authorization form.

Your Medical Information

Each time you or your child visit me information is collected about you or you child's physical or mental health. It may be information about you or your child's past, present or future health or condition, the treatment or services received, or about payment for health care. This information is called PHI, which stands for Protected Health Information. The information I obtain from you or your child goes into your or your child's medical record at my office. It is likely to include the following:

• Your or your child's personal history
• Reasons you or your child came for treatment: problems, symptoms, needs, goals
• Diagnoses: medical terms for you or your child's problems, symptoms, disabilities
• Treatment Plan: services that I think will help you or your child
• Progress Notes
• Records from others who treated or evaluated you or your child
• Psychological test scores, school records, and the like
• Information about medications you or your child are taking
• Legal matters
• Billing and insurance information

Medical information is used for many purposes. For example I may use it to:

• Plan your child's care
• Decide how well my treatment is working for you
• Talk with other health care professionals who are also treating you or your child, such as your

family doctor or the professional who referred you to me
• Show that you actually received the services from me that I billed to you or your health insurance company

How Protected Health Information Can Be Used and Shared

When you or your child's information is read by me or others, it is called "use." If the information is shared with or sent to others outside this office, it is called "disclosure." Except in some special circumstances, when I use you or your child's PHI or disclose it to others, I share only the minimum necessary PHI needed for the purpose. The law gives you rights to know about your PHI, how it is used, and to have a say in how it is disclosed.

Use or disclosure of the following protected health information
does not require your consent of authorization:

1. Uses and disclosures required by law-*like files court-ordered by a Judge*
2. Uses and disclosures about victims of abuse, neglect, or domestic violence-*like the duties to warn explained in the Disclosure Statement*
3. Uses and disclosures for health and oversight activities-*like correcting records or correcting records already disclosed*
4. Uses and disclosures for judicial and administrative proceedings-*like a case where you are claiming malpractice or breech of ethics*
5. Uses and disclosures of law enforcement purposes-*like if you intend to harm someone else*
6. Uses and disclosures to avert a serious threat to health or safety-*like calling Probate Court for a commitment hearing*
7. Uses and disclosures for Worker's Compensation-*like the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim*

Your Rights as a Patient under HIPAA

1. As a client, you have the right to see your file, unless it would endanger your health or another person's health or safety. *Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are excluded from this right.*
2. As a client, you may obtain a copy of your treatment, or a summary of your treatment. There is a standard administrative fee for copies a fee for a treatment summary may apply.
3. As a client, you have the right to request amendments to your counseling/therapy file
4. As a client, you have the right to receive a history of all disclosures of protected health information. You will be required to pay any copying fees @ $.20 a page as well as a fee for my time.
5. As a client, you have the right to restrict the use and disclosure of your PHI for the purpose of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.

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6. As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.
Prior to your treatment, you will receive an exact duplicate of these pages and the Professional Disclosure Statement. It will be necessary for you to sign a certificate indicating that you have received, read and understood both documents. This certificate will be placed in your file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights of the Professional Disclosure Statement. I will be happy to explain these documents further.

In summary, HIPAA and Washington State law provide you with certain rights regarding your clinical record and disclosure of protected health information about you. These rights include:

• requesting that I amend your record
• requesting restrictions on what information from your clinical record is disclosed to others
• requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized
• determining the location to which protected information disclosures are sent
• having any complaints you make about my policies and procedures recorded in your records
• receipt of a copy of this Notice of Privacy Practices form

I acknowledge that I have received and read the ***Professional Disclosure Statement*** and the ***HIPAA Client's Rights.*** I further acknowledge that I seek and consent to treatment with my therapist. My signature below confirms that I understand and accept all the information contained in the ***Professional Disclosure Statement*** and the ***HIPAA Client's Rights.***

_____

Printed name of Client

_____ _____

Signature of Client Date

_____ _____

Parent Signature Date