

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all medical records and other individually identifiable health information used or disclosed by me in any form are kept confidential. This act gives you, the client, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

When you receive psychotherapy services from this practice, we create a record of the services that you received. We need this record in order to provide you with quality care and to comply with legal requirements. We understand that health information about you and the health/mental health care you receive is personal, and we are committed to protecting your personal health information. It is also our legal duty to do so, and to provide you with this notice about our privacy procedures. **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.**

Use of protected health information (PHI) applies only to activities within this practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. PHI is disclosed when the practice releases, transfers, gives, or otherwise reveals it to a third party outside of this practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this notice.

How would the practice use and disclose your protected health information?

We may use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorizations; others, however, will not. Below you will find the different categories of our uses and disclosures, with some examples.

I. Uses and Disclosures Related to Treatment, Payment, and Health Care Operations That Do Not Require Your Prior Written Consent. We may use and disclose your PHI without your written consent for the following reasons:

1. **For treatment.** We can use your PHI within this practice to provide you with mental health treatment. Although as a general rule we will attempt to discuss with you any disclosure to your other service providers, we are legally permitted to disclose your PHI to physicians, psychiatrists, psychologist, and other licensed health care providers who provide you with health care services, or who are otherwise involved in your care. However, we generally will not do so without first discussing this with you. For example, if a psychiatrist is treating you, we may disclose your PHI to them in order to coordinate your care.
2. **For health care operations.** These are activities that relate to the efficient performance and correct operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
3. **To obtain payment for treatment.** We may use and disclose your PHI to bill and collect payment

for the treatment and services we provided you. For example, we might send your PHI to your insurance company or health plan in order to get payment for the health care services that we have provided to you.

4. **Other disclosures.** Your consent isn't required if you need emergency treatment, provided that we attempt to get your consent after treatment is rendered. In the event that we try to get your consent, but you are unable to communicate with us (for example, if you are unconscious or in severe pain) but we think that you would consent to such treatment if you could, we may disclose your PHI.

II. Certain Other Uses and Disclosures That Do Not Require Your Consent or Authorization. We may use or disclose PHI without your consent or authorization for the following reasons:

1. **Child abuse or neglect.** If we have reasonable cause to suspect that a child is abused or maltreated where the parent, guardian, custodian, or other person legally responsible for such child comes before us and states from personal knowledge facts, conditions or circumstances, which, if correct, would render the child an abused or maltreated child, we must report such abuse or maltreatment to the local child protective services agency.
2. **Adult/elder abuse or neglect.** Same as above. We must report such abuse or maltreatment to the local adult protective services agency.
3. **Health oversight:** If there is an inquiry or complaint about our professional conduct made to any governing body (i.e. Virginia Board of Social Work, Maryland Board of Social Work Examiners, District of Columbia Board of Social Work), we must furnish to this organizing body your confidential mental health records relevant to this inquiry.
4. **Judicial or administrative proceedings.** If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under Federal and Virginia law, and we must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party, or where the evaluation is court ordered. We must inform you in advance, if this is the case.
5. **Serious threat to health or safety.** We may disclose your confidential information to protect you or others from a serious threat of harm by you.
6. **Worker's compensation.** If you file a worker's compensation claim, and we are treating you for the issues involved with that complaint, then we might be required to furnish to the chairman of the Worker's Compensation Board records, which contain information regarding your psychological condition and treatment.
7. **To obtain payment for treatment.** We may use and disclose your PHI to bill and collect payment for the treatment and services we provided you. For example, we might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you.
8. **If disclosure is otherwise specifically required by law.**

III. Uses and Disclosures Requiring Authorization

In any other situation not addressed above, we will request your written authorization before using or disclosing any of your PHI. And "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for the purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes to anyone. "*Psychotherapy notes*" are notes that we have made about conversation between you and any clinician of the practice during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. Finally, your written consent will be necessary in order to

have contact with you through non-secure voice and/or data communications (i.e. cellular phone and/or email).

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

What Rights You Have Regarding your PHI

1. **Right to Inspect and Get Copies of your PHI.** In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. You will receive a response from us within 30 days of our receiving your written request. If you ask for copies of your PHI, we will charge you not more than 25 cents per page. We may see fit to provide you with a summary of explanation of the PHI, but only if you agree to it, as well as to the cost, in advance. We may deny your access to PHI under certain circumstances, but if we do, we will give you, in writing, the reasons for the denial. We will also explain your right to have our decision reviewed. On your request, we will discuss with you the details of the request and denial process.
2. **Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclosure your PHI. While we will consider your request, we are not legally bound to agree. If we do agree with your request, we will put those limits in writing and abide by them, except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.
3. **Right to Choose How We Send Your PHI to You.** It is your right to ask that your PHI be sent to you by alternative means and/or at an alternative address. (For example, you may not want a family member to know that you are being seen in this practice. Upon your request, we will send your bills to another address.)
4. **Right to Amend.** If you believe that there is some error in your PHI, or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information. Your request and the reasons for the request must be made in writing. You will receive a response within 60 days of our receipt of your request. We may deny your request, in writing, if we find that: The PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone other than us. Our denial must be in writing and must state the reasons for the denial. If you do not file a written objection, you still have the right to ask that your request, and our denial, be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.
5. **Right to Get a List of the Disclosures We Have Made.** You generally have the right to receive an accounting of disclosures of PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those from treatment, payment, or health care operations, sent directly to you, or your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel. Disclosure records will be held for six years.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, it is our sincere hope is that you would contact us directly.

If you believe that your privacy rights have been violated, you may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, the office that oversees HIPAA. We can provide you with the appropriate address upon request. Understand that you have specific rights under the Privacy Rule. If you file a complaint about this practice's privacy practices, we will not retaliate against you.

VI. Effective Date, Restrictions and Chances to Privacy Policy

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by notifying you and providing you a new copy. This Notice of Privacy Practices is effective on March 20, 2023.

ACKNOWLEDGEMENT AND CONSENT FOR NOTICE OF PRIVACY PRACTICES

Signing this document means that I have read the Notice of Privacy Practice, have received a copy, and have been made aware of how this practices medical records can be used or disclosed.

Your signature below indicates that you have read this agreement and agree to its terms and conditions.

_____	_____	_____
Client/Guardian Full Name	Client/Guardian Signature	Date
_____	_____	
Client/Guardian Signature	Date	