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HIPAA PRIVACY NOTICE

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

· **"*PHI*"** refers to information in your health record that could identify you.

· **"*Treatment, Payment and Health Care Operations*"**

- **Treatment** is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.
- **Payment** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- **Health Care Operations** are activities that relate to the performance and operation of my 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.

· **"*Use*"** applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

· **"*Disclosure*"** applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An **"authorization"** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. **"Psychotherapy notes"** are notes I generally make about our conversation during a private, group, joint, or family counseling session, which I keep separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

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) I 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.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

· **Child Abuse**: If there is reasonable cause to believe that a child has been subject to abuse, this must be reported immediately to the following agencies: NYC - NYC Administration for Children's Services (ACS), NJ - the Child Protection and Permanency, CP&P (formerly the Division of Youth and Family Services, DYFS).

· **Adult and Domestic Abuse**: If there is reason to believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, the information may be reported to the county adult protective services provider.

· **Health Oversight**: If the New York State Board of Social Worker Examiners or the New Jersey State Board of Social Worker Examiners issues a subpoena, this may compel testifying before the Board and produce your relevant records and papers.

· **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I 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. I must inform you in advance if this is the case.

· **Serious Threat to Health or Safety**: I may disclose your confidential information to protect you or others from a serious threat of harm by you.

· **Worker's Compensation**: If you file a worker's compensation claim, and I am treating you for the issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records which contain information regarding your psychological condition and treatment.

IV. Patient's Rights and Therapist's Duties

Patient's Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

· **Get an electronic or paper copy of your medical record -** You can ask to see or get an electronic or paper copy of your medical record and other health information I have about you. I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.

· **Right to inspect and copy** – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

· **Ask to correct your medical record -** You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this. I may say "no" to your request, but I'll tell you why in writing within 60 days.

· **Ask to limit what I use or share -** You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask me

not to share that information for the purpose of payment or my operations with your health insurer. I will say "yes" unless a law requires me to share that information.

· **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. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

· **Get a list of those with whom I've shared information -** You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why. I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

· **Get a copy of this privacy notice-** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.

· **Choose someone to act for you -** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. I will make sure the person has this authority and can act for you before I take any action.

Therapist's Duties:

· I am 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.

· I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

· I will not use or share your information other than as described here unless you tell me I can in writing. If you tell me I can, you may change your mind at any time. Let me know in writing if you change your mind.

· I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

· If I revise my policies and procedures, I will mail the revised Notice to you.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 718-314-9280.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to my office.

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

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VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on _____.

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

Your signature and date below acknowledge that you have been provided with this document regarding policies and practices concerning your protected health information (PHI).

Your signature below also gives general consent for use or disclosure of your protected health information (PHI) for treatment, payment, and health care operations purposes. Your signature also allows me to leave voicemail messages at the telephone numbers you provide and/or send emails regarding confirming/changing appointments.

_____ _____

Client's Signature **Date**

_____ _____

Therapist's Signature **Date**