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Notice of Privacy Practices

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

My Commitment To Protecting Your Personal Health Information

My practice is dedicated to maintaining the privacy of your Protected Health Information ("PHI"). I am also required to do this under State and Federal law, and the ethics of my profession. While the laws protecting the privacy of your PHI are complicated, it is my desire and obligation under the HIPAA Privacy Rule to provide you with certain important information prior to the initiation of treatment.

This Notice explains my privacy practices and legal duties, and your rights concerning the use or disclosure of your PHI and certain exceptions. The terms "PHI," "Health Information," and "Information," as used in this notice all refer to information that I maintain that could reasonably be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. In general, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is authorized.

I will follow the privacy practices described in this Notice while it is in effect. I may change my privacy practices and the terms of this notice at any time. If I make a material change to my privacy practices, I will provide you with a revised notice by direct mail or electronically as permitted by applicable law. You may also request a copy of this notice at any time or view a copy of it in my office or on my website. Any revisions to this notice will be effective for Information that I already have, and that I may receive in the future.

How I Will Protect Your Health Information

I will protect your Health Information by:

- Treating all of your Health Information that I collect as confidential. This means that with limited exceptions, as discussed below, I will not share your Health Information with anyone without your consent or written authorization;
- Restricting access to your Health Information to those clerical staff and the referring doctor who need to know your Health Information in order to provide services to you;
- Only disclosing that Health Information that is necessary for an outside service company (such as testing, billing, and transcription services) to perform its function on my behalf. Such companies have agreed to protect and maintain the confidentiality of your Health Information by a separate Business Associate's Agreement;

Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your Health Information.

How I May Use or Disclose Your Health Information

I will use the Health Information that I obtain from you and the Information I obtain from

others about you to provide you with **Treatment**, arrange **Payment** for my services, and to perform other **Healthcare Operations**. In conjunction with this Notice, I will ask you to sign a Consent and Authorization for Psychological Treatment which will permit me to **Use** and **Disclose** your Health Information for these purposes. You have the right to choose not to sign the form. However, if you do not sign the form, I cannot treat you. If I want to use or disclose your Information for any purpose other than as stated in this paragraph, such as sharing your information with another healthcare provider, I will discuss this with you and ask you to sign a separate Authorization prior to any such disclosure, unless an exception applies as discussed below.

To help clarify these terms, here are some helpful definitions:

- **Treatment** is when a clinician provides, coordinates, or manages your healthcare and other services related to your healthcare. An example of treatment would be when we meet together for an appointment session, or when I share your Health Information with other healthcare providers working within my practice who are providing you with healthcare services or are otherwise involved in your care, such as my trainees, psychological assistants or interns. I may also disclose your PHI to physicians, psychiatrists or other psychologists pursuant to your written authorization. For example, if a psychiatrist is treating you, I may disclose pursuant to your written authorization certain Health Information to him or her to coordinate your care.

- **Payment** is when a clinician obtains reimbursement for your healthcare. For example, I may disclose certain limited Health Information to your health insurer to obtain reimbursement for my services, or to determine eligibility or coverage, or with business associates who have signed a separate contract with me to safeguard your PHI so that they may process or recover claims for reimbursement on my behalf.

- **Healthcare Operations** are activities that relate to the performance and operation of my practice. Some examples of healthcare operations include quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination, accreditation activities or the sale of my practice.

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

- **Disclosure** applies to the sharing of your Health Information outside of my practice. Examples include releasing, transferring, or providing access to your Health Information to other parties such as your family physician or your attorney.

Uses Or Disclosures That Do <u>Not</u> Require Your Consent

There are times when I am *required* by law to disclose certain Health Information whether I want to or not. There are also times when I am *permitted* to use or disclose certain Health Information without your consent. Under each such circumstance, I will try to inform you that I intend to disclose the Information, and discuss it with you, even though your consent is not required. I must or may disclose Health Information without your consent for the following reasons:

1. **Where disclosure is required by law.** Some examples of situations where I may be required to disclose your Health Information include the following:

    - For Reporting Victims of Child, Elder or Dependent Adult Abuse or Neglect to government authorities that are authorized by law to receive such Information, including a law enforcement, social services or protective services agency; this

includes circumstances in which I reasonably suspect that you are knowingly downloading, streaming or accessing digital or other electronic media sexually depicting a minor;

- For Judicial or Administrative Proceedings such as in response to a court order, or lawfully executed search warrant;

- To Avoid a Serious Threat of Physical Harm to Health or Safety to you, another person, or the public, by, for example, disclosing Information to law enforcement and a reasonably identifiable victim;

- For Specialized Government Functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- For Workers' Compensation to the extent necessary to comply with state workers compensation laws that govern job-related injuries or illnesses.

Upon request by your legal representative such as a conservator or one with durable powers of attorney for healthcare decisions under circumstances where you have been determined to lack capacity to make healthcare decisions.

2. **Where disclosure is permitted by law.** Examples of circumstances where I may provide your Health Information without your consent include the following:

- For payment of healthcare services such as to your insurer, healthcare service plan, employee benefit plan, or a governmental authority, contractor, or other person or entity responsible for paying for my services to the extent necessary to allow responsibility for payment to be determined and payment to be made. Note that under California law, you are entitled to a copy of the written request for PHI by the person or entity requesting the PHI unless you have waived your right to such notice in writing. The notice must provide you with (1) a description of the specific information being requested relating to your participation in outpatient psychological treatment, together with a description of the specific intended use or uses; (2) The length of time during which the information will be kept before being destroyed or disposed of; (3) A statement that the information will not be used for any purpose other than its intended use; and (4) A statement that the person or entity requesting the information will destroy the information and all copies in the person's or entity's possession or control, will cause it to be destroyed, or will return the information and all copies of it before or immediately after the length of time specified in the notice has expired. The notice must be provided by the person or entity requesting the information to you within 30 days of receipt of the information requested, unless you have signed a written waiver waiving notification.

- To Business Associates that perform healthcare functions on my behalf or provide me with services if the Information is necessary for such functions or services. An example of such a Business Associate would be testing services that I may utilize in order to provide you with psychological testing. Business Associates are required by a separate contract to protect the privacy of your Information. They are not allowed to use or disclose any Information other than as specified in their contract.

- For Data Breach Notification Purposes. I may use your contact Information to provide legally-required notices of unauthorized acquisition, access or disclosure of your Health Information, if such were to occur. I may send notice

directly to you or provide notice to the sponsor of the health plan through which you receive coverage.

Uses Or Disclosures That Require Your Consent.

Except for uses and disclosures which are permitted or required by law, I will use and disclose your Information only with a written authorization from you. Once you give me authorization to release your Information, I cannot guarantee that the person to whom the Information is provided will not redisclose the Information. You may take back or "revoke" your written authorization at any time in writing, except if I have already acted based on your authorization. For more information regarding providing or revoking your written authorization, please ask me for a copy of my Authorization for Use or Disclosure of Health Information Form.

What Are Your Rights

The following are your rights with regard to your Health Information:

1. **The Right to Access and Copy Your PHI**. You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Under California law, you have the right to inspect a copy of your records within 5 *working* days of providing a written request for inspection, and the right to have a copy transmitted to you within 15 *calendar* days of your providing a written request and paying a reasonable fee to defray the costs of copying the record, not to exceed $0.25 per page in addition to the reasonable clerical costs incurred in making the records available. Under certain circumstances, I may deny your access to PHI or elect to provide you with a summary or explanation of your PHI as a compromise with your consent at an agreed-upon cost. You may have this decision reviewed, and upon your request, I will discuss the details of the request and denial process with you.

2. **Right to Limit Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I 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 I am legally required or permitted to make.

3. **The Right to Choose How I Send Your PHI to You**. It is your right to ask that your PHI be sent to you in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address.) I will accommodate reasonable requests where a disclosure of all or part of your Health Information could endanger you.

4. **The Right to Receive an Accounting of Disclosures.** You are entitled to a list of certain disclosures of your PHI that I have made within the six years prior to your request. The list will not include uses or disclosures of information made (i) prior to April 14, 2003; (ii) for treatment, payment, and healthcare operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions, or law enforcement officials; and (v) other disclosures for which federal law does not require me to provide an accounting.

   I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, the identity of the person or entity to whom PHI was disclosed (including their address, if known), a description of the Information

disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

5. **The Right to Amend Your PHI.** 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 I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request.

   If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

   I may deny your request if I find that the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI.

6. **The Right to a Copy of this Notice.** You may ask for a copy of this notice at any time. In addition, a copy will be provided to you whenever a material change to this notice has been made.

7. **Patient's Right to Confidentiality Following Death.** Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. However, California law prohibits the release of a deceased patient's records at any time except to the administrator or personal representative of the patient's estate.

How to Complain about my Privacy Practices

If you believe that your privacy rights have been violated, you may contact this office by phone or by mail. You may also send a written complaint to either of the following:

1) Secretary of the Department of Health and Human Services
   200 Independence Avenue S.W.
   Washington, D.C. 20201

2) Office of Civil Rights, U.S. Department of Health & Human Services
   90 7th Street, Suite 4-100
   San Francisco, CA 94103
   (415) 437-8310; (415) 437-8311 (TDD); (415) 437-8329 FAX;
   Web: http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintpackage.pdf

If you file a complaint about my privacy practices, I will take no retaliatory action against you.

Effective Date of this Notice: September 1, 2018.

I acknowledge receipt of this notice and I have read the above HIPAA Notice of Privacy Practices carefully; I understand them, and any questions have been answered:

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

If the patient is under the age of 18-years-old or a dependent adult:

_____
Printed Name of Responsible Party

_____ _____
Signature of Responsible Party Date

_____
Printed Name of Responsible Party

_____ _____
Signature of Responsible Party Date

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the HIPAA Notice of Privacy Practices was not obtained:

_____ Patient refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Other(s): _____.