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# HIPAA & Notice of Privacy Practices

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.***

As a Clinical Social Worker licensed by the State of California to provide psychotherapeutic counseling, I am committed to protecting the personal and health information (PHI) of my clients in each of the settings in which such information is received or disclosed.

**MY LEGAL DUTY**

As a recipient of health care services, you have certain rights. To learn more about these rights, I encourage you visit: https://www.hhs.gov/hipaa/for-individuals/index.html. I am required by law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, my legal duties, and your rights concerning your health information. I will follow the privacy practices that are described in this Notice while it is in effect.

**USE AND DISCLOSURES OF HEALTH INFORMATION**

When you complete an application for health coverage, your signature authorizes your health plan organization to collect personal information about you such as your social security number, date of birth, address, telephone number, etc. As a member of your health plan organization's program, this general consent allows your health plan organization to communicate with me as your authorized provider about treatment and payment decisions.

Health plan organizations typically participate in quality measurement activities that may require them to access your PHI. They are required to have policies to protect this information from inappropriate disclosure and release this information only if aggregated or encoded.

I will not disclose, sell, or otherwise use your PHI unless permitted by law for protection of personal safety and the extent necessary to coordinate your benefit.

I will obtain written authorization from you to use your PHI for any other purpose than indicated above. Any client unable to give consent may designate a legally authorized representative to give consent on his or her behalf.

I will not release your PHI to your employer without your specific authorization, unless law requires such release.

**Required by Law:** I may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** I may disclose your health information to appropriate authorities if I reasonably believe that you may be a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

**Appointment Reminders:** I may use or disclose your health information to provide you with appointment reminders.

**PATIENT RIGHTS**

**Access:** With a minimum of one week (seven days) notice, you may inspect your records, and when needed, you may request a written statement for your own purposes. You also have the right to request an accounting of disclosures of your PHI made

for purposes other than those stated above. You may request copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information by sending me a letter to the address at the end of this Notice.

**Disclosure Accounting:** You have the right to receive a list of instances in which I have disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6years. I will provide such a list at no charge upon your request once in any 12-month period. I reserve the right to charge you for requests in excess of one per 12-month period.

**Restrictions:** You have the right to request that I place additional restrictions on the use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that I communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that I amend your health information. (Any such request must be in writing, and it must explain why the information should be amended.) I may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon your request.

**QUESTIONS AND COMPLAINTS**

To learn more about my privacy practices or have questions or concerns, please contact me. If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may contact me using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. I will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

I support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

**Acknowledgement:** I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

**By signing, I confirm that I have read & received a copy of the above statement.*

Signature: _____

Printed Name: _____

Date Received: _____

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