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Notice of Privacy Practices (HIPPA)

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 the information in your health record that could identify you.

I may use or disclose your PHI for three purposes: treatment, obtaining payment, and what are called 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 psychologist.
--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, to determine eligibility for coverage, or when identifying the service you have received from me when you use credit card as a method of payment.
--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, case management and care coordination, and my consultation with a supervisor or other professionals to better assist you.
--"Use" applies only to activities within my office and practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
--"Disclosure" applies to activities outside of my office and practice 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 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 have made about our conversation during a private, group, joint, or family therapy session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. When I use your PHI or disclose it to others, I share only the minimum amount of information necessary for those other people to do their jobs.

- To individuals involved in your care-When appropriate, your health information may be disclosed to a family member or close friend assisting you in receiving or obtaining payment for health care services. I will disclose your health information to these individuals only if you tell me to do this or if I can reasonably infer that you do not object. I may also disclose your health information to disaster relief organizations to assist in locating you in the event of a disaster.
- Appointments, Information or Services- I may contact you regarding appointments or other health-related services that may be of interest to you. I may also use or disclose your health information for judicial or administrative proceedings, for specialized government functions, for workers' compensation or similar purposes. If you want me to call or write to you only at your home or your work or prefer some other way to reach you, I can usually arrange that.
- Business Associates- There are some tasks I may hire other businesses to do for me. Examples include a copy service used to make copies of your health records, or a bookkeeper. These business associates need to receive some of your health information to do their jobs properly. To protect your privacy, they agree in their contract with me to safeguard your information.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- Child Abuse or Neglect: If, in my professional capacity, I know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, of condition of nature that reasonably indicates abuse or neglect, I am required by law to immediately report that knowledge or the appropriate authority.
- Adult and Domestic Abuse: If I have reasonable cause to believe that an incapacitated adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, I am required by law to immediately report such belief to Adult protective Services
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis, and treatment and the records thereof, such information is privileged under state law and I will not release this information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: If I believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I am required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate this possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency, and, if feasible, to the potential victim(s), or victim's parent or guardian, if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
- Worker's Compensation: If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials.

IV. Patient's Rights and Therapist's Duties

You may revoke all such authorization (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 the 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.

Patient Rights

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- 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 you request, I will send unpaid bills to another address). Your request must specify how or where you wish to be contacted
- 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 record 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 ask for this decision to be reviewed. On your request, I will discuss with you the details of the request process.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained

in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent not authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

*Any requests of the nature described above must be made in writing and addressed to me.

Therapist 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 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 notify you of the revised notice by mail or in person.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. I promise that I will not in any way limit your care or take any actions against you if you complain.

Effective Date 4.1.2013

PATIENT ACKNOWLEDGMENT

I have read, understood, agree, and acknowledge receiving a copy of Sarah Perl, LCSW's (HIPPA) Notice of Privacy Practices:

Signature:_____

Name (Printed): _____

Date:_____