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# Notice of Privacy Practices

Health Insurance Portability Accountability Act (HIPAA)
Client Rights and Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

As part of my professional practice, I collect and create personal information about you and your health. State and federal law protects your privacy by limiting me in how I may use and disclose such information. Protected Health Information is information about you, including demographic data, that may identify you or be used to identify you, and that relates to your past, present, or future physical or mental health or condition, the provision of health care services, or the past, present, or future payment for the provision of health care.

HIPAA requires that I provide you with a Notice of Privacy Practices (this Notice), which explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. If you have any questions, it is your right and obligation to ask so I can have a further discussion with you prior to signing this document. When you sign the form acknowledging this document, it will also represent an Agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

## Limits on Confidentiality

The law protects the privacy of communication between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Some of the reasons I may have to release your information without authorization include:

1. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
2. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
3. I may disclose the minimum necessary health information to my business associates that perform functions on my behalf or provide me with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
4. I may be required to disclose your PHI if a court issues an appropriate order, I have received satisfactory assurances that you received notice of your right to seek a protective order, no qualified judicial or administrative protective order has been obtained, and the time for your doing so has elapsed.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with Child Protective Services (Washington State Department of Children, Youth, and Families). Once such a report is filed, I may be required to provide additional information.

2. If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with Adult Protective Services (Washington State Department of Social and Health Services). Once such a report is filed, I may be required to provide additional information.

3. If I believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to larger society, I may be required to disclose information to take protective action. This may include communicating the information to the potential victim, the police, crisis responders, the client's emergency contact, or others to provide appropriate assistance, or to seek hospitalization of the client.

## Client Rights and Therapist Duties

**Use and Disclosure of Protected Health Information:**

- **For treatment.** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of my practice for your treatment by another health care provider, I will have you sign an authorization for release of information.
- **For payment.** I may use and disclose your health information to obtain payment for services provided to you as delineated in the Financial Policy Agreement.
- **For operations.** I may use and disclose your health information as part of the internal operations of this practice. For example, this could mean a review of records to assure quality care. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

**Client's Rights:**

- **Right to treatment.** You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- **Right to confidentiality.** You have the right to have your health care information protected. When paying for services privately, you have the right to instruct me not to keep records in therapy. I will agree to such unless the law requires me to share that information. In the case that notes are restricted per the client's request, the basic information retained will include client name, the financial agreement and record of payments, dates of service, the clinical disclosure statement, the consent for treatment, and the client's request to refrain from recording treatment notes.
- **Right to request restrictions.** You have the right to request restrictions on certain uses and disclosures of PHI about you. However, I am not required to agree to a restriction you request.
- **Right to request confidential communication.** You have the right to request that I communicate with you in a certain way or at a certain location. I will accommodate reasonable requests if appropriate and feasible.
- **Right to inspect and copy.** You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and a release of information must be completed. There is a fee to copy records, as outlined in the Financial Policy Agreement. Please make your request well in advance and allow 30 days to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- **Right to amend.** If you feel the PHI I have about you is incorrect or incomplete, you may ask me in writing to amend the information. I am not required to agree to the amendment. You may write a statement of disagreement if your request is denied. The statement will be maintained as part of your PHI and will be included with any disclosures made. If I refuse to amend the record, I will provide you with a reason within 60 days.
- **Right to a copy of this Notice.** If you received this paperwork electronically, a current copy is available to you. You have the right to obtain another copy of this Notice any time upon request.
- **Right to an accounting.** I am required to create and maintain a prescribed accounting of certain disclosures I may have made of your PHI. You have the right to request a copy of such an accounting.
- **Right to choose someone to act for you.** 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 legitimate authority and can act for you before I take any action.
- **Right to choose.** You have the right to decide not to receive services from me. If you wish, I will provide you with names of other providers, agencies, or organizations you may contact.
- **Right to terminate.** You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating, or at least contact me by phone letting me know you are terminating services.

- **Right to release information with written consent.** With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

**Therapist's Duties:**

I am required by law to maintain the privacy of your PHI, to provide you with notice of my legal duties and privacy practices with respect to your PHI, and to notify you following a breach of unsecured PHI related to you. 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 provide you with an updated copy of this Notice.

**Complaints**

I am my own Privacy Officer. If you have any questions about this Notice, are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please contact me. I will not retaliate against you for discussing any of these things with me.

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You may also contact the Washington State of Department of Health, or the Secretary of the Department of Health and Human Services with any concerns.

Once you have had an opportunity to read this Notice I will ask you to sign a separate form, Consent for Treatment: Acknowledgement of Receiving Notice of Privacy Practices and Clinical Disclosure Statement. Your signature on that form will indicate that you have received and read this Notice, had an opportunity to ask any questions, that you understand and agree to these policies, and you allow the disclosures of your health information as described.

**The effective date of this revised Notice is December 1, 2023.**