Nance Reynolds, PhD, LCSW **INSIGHT THERAPY**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Understanding the contents of your Clinical Record and how that information is used will (1) help you to better understand when others may have access to your health information and (2) assist you in making more informed decisions when authorizing disclosures. Your record is the physical property of Nance Reynolds LCSW, RN; the information within the record belongs to you. In using and disclosing your health information, it is my policy to be in compliance with the Privacy Standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

1. 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 this statement, the following definitions are provided: **"Use"** applies to activities within my office such as utilizing, examining, and analyzing your PHI. **"Disclosure"** applies to activities outside my office, such as releasing, transferring, or providing access to your PHI. **"Protected Health Information (PHI)"** refers to any individually identifiable health information maintained or transmitted by me that relates to (1) the past, present, or future physical or mental health or condition of an individual; (2) the provision of health care to an individual; or (3) the past, present, or future payment for the provision of health care to an individual.

"Treatment" is when I provide, coordinate, or manage your health care and other services related to your health care. This includes when I consult with other health care providers, such as your family physician, LCSW, psychologist, and when I make referrals. **"Payment"** includes what a health care plan does to collect premiums, determine eligibility and coverage, and provide payments. This includes when I disclose your PHI to your health insurer to determine eligibility or coverage or to obtain reimbursement. **"Health Care Operations"** are activities that relate to the performance, operation, and maintenance 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. **"Consent"** refers to your consent and agreement, which you indicate by your signature on the ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES or the AGREEMENT AND INFORMED CONSENT FOR TREATMENT. **2. Uses and Disclosures Requiring Authorization**

I may use or disclose confidential information, including but not limited to PHI, for purposes of treatment, payment, and health care operations when your written informed consent has been obtained. I may also use or disclose your PHI for purposes outside of treatment, payment, and health care operations only with your written AUTHORIZATION. An AUTHORIZATION will also be needed before releasing any Psychotherapy Notes.

An **"Authorization"** is specific, written permission above and beyond general consent. When information is requested for purposes other than treatment, payment, and health care operations, I will obtain an AUTHORIZATION from you before releasing the information. **"Psychotherapy Notes"** are notes I may have made about our conversations during therapy, which I have kept separate from the rest of your Clinical Record. These Notes are given a greater degree of protection than your PHI. You may revoke an AUTHORIZATION at any time, provided the revocation is in writing. You may not revoke an AUTHORIZATION to the extent that (1) I have relied on the AUTHORIZATION or (2) the AUTHORIZATION was obtained as a condition of obtaining insuranc coverage, and the law provides the insurer the right to contest the claim under the policy. 5-1-2011**3. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose your PHI without your consent or authorization in the following circumstances. If any of these situations arise, whenever possible, I will make every effort to discuss it with you before taking action, and I will limit my disclosures to what is minimally necessary. ◆ **Child Abuse:** If I have reasonable cause to believe that a child has been abused, I may be required to report the abuse and turn over PHI. Regardless of whether I am required to disclose PHI, I also have an ethical obligation to prevent harm to my clients and

others. I will use my professional judgment to determine whether it is appropriate to disclose PHI. ◆ **Filing Insurance Claims**: I may file insurance claims with information about your address, employment, age, diagnosis. ◆ **Abuse of Mentally Ill or Developmentally Disabled Adults:** If I have reasonable cause to believe that a mentally ill or developmentally disabled adult has been abused, I may be required to report the abuse and turn over PHI. Regardless of whether I am required to disclose PHI, I also have an ethical obligation to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI. ◆ **Other Abuse:** If I have reasonable cause to believe that other forms of abuse have occurred, I may have an ethical obligation to disclose PHI in order to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI. ◆ **Clear and Immediate Danger:** If I believe that there is a clear and immediate danger to others or society, I may report relevant information to the appropriate authorities. ◆ **Future Crimes:** If I believe there is a clear and serious intent to commit a future crime involving physical injury, threat to physical safety of anyone, sexual abuse, or death; and if I believe there is a danger of the crimebeing committed; then I may report information to the authorities. ◆ **Medical Emergency:** I may disclose PHI that would facilitate treatment in the case of a medical emergency or involuntary commitment. This includes situations where a person poses a danger to self or others. Such disclosures may also be covered under HIPAA. ◆ **Legal Proceedings and Court Orders:** I may have to release your PHI if (1) you become involved in a lawsuit and your mental or emotional condition is an element of your claim, or (2) a court orders your PHI to be released or orders your mental evaluation. ◆ **Worker's Compensation Claim:** If you file a Worker's Compensation claim, this authorizes me to release all relevant records to involved parties and officials. This includes any past history of complaints or treatment of conditions similar to those involved in the claim. ◆ **Legal Defense:** If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself. ◆ **Government Health Oversight:** If the Oregon State Board of Clinical SocialWorkers or a government agency requests PHI for health oversight activities, I may be required to provide it. While this summary of the exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In specific situations, formal legal advice may be needed. **4. Client's Rights** HIPAA provides you with the following rights with regard to your Clinical Record and disclosures of your Protected Health Information. I will be happy to discuss any of these rights with you upon request. Should you wish to utilize any of these rights, please make your request in writing. If necessary, I can provide you with the proper form or procedure.

◆ **Right to Request Restrictions:** You have the right to request restrictions on the uses and disclosures of your PHI. However, I am not required to agree to a restriction that you request. ◆ **Right to Receive Confidential Communications:** You have the right to request that I communicate with you in certain ways or at certain locations. For example, you can ask that I only contact you at work or by mail. All reasonable requests will be accommodated.

◆ **Right to Inspect Records:** You have the right to inspect and/or 5-1-2011 receive a copy of your PHI in my mental health and billing records for as long as the PHI is
maintained in the record. You may be charged a copying/printing fee of $15 plus 50¢ per page plus any postage. I may deny 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. ◆ **Right to Amend:** You have the right to request an amendment of your PHI for as long as the PHI is maintained in the record. However, I am not required to agree to your amendment. On your request, I will discuss with you the details of the amendment process. ◆ **Right to an Accounting:** You have the right to receive an accounting of disclosures of your PHI for which you have neither provided consent nor authorization (as described in Section 3 of this NOTICE). I am not required to account for disclosures for treatment, payment, health care operations, or pursuant to an authorization, among other exceptions. On your request, I will
discuss with you the details of the accounting process. ◆ **Right to a Paper Copy:** You have the right to obtain a paper copy of the NOTICE from me
upon request, even if you have agreed to receive the NOTICE electronically.

Practitioner's Duties

◆ I have a legal duty to maintain the privacy of your PHI. ◆ I will abide by the terms of the current NOTICE. ◆ I will not disclose your PHI for any other purpose without your AUTHORIZATION. ◆ I will

make sure that all business associates comply with HIPAA regulations and procedures. ◆ If I revise the NOTICE, I will post a summary of the revised NOTICE in my office. ◆ Upon request, I will provide you with a copy of the current NOTICE. ◆ If state or federal law prohibits or further restricts disclosure of your PHI, I will follow the more stringent law.

6. Complaints

If you believe that your privacy rights have been violated, please contact me immediately, so that we can attempt to address your concerns together. If you are not satisfied with our resolution of your concerns, you may file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. I can provide you with the appropriate form and address upon request, and you will not experience any retaliation from me for filing a complaint.

7. Effective Date, Restrictions, and Changes to Privacy Practices

The effective date of this NOTICE is located in the bottom right corner of the page. I reserve the right to change the terms of this NOTICE and to make the revised or changed NOTICE effective for all PHI that I maintain, including PHI collected previously. I am not obligated to tell you when the NOTICE has changed, but I will post a summary of the revised NOTICE in my office, with its effective date in the bottom right corner. You are entitled to request and receive a copy of the current NOTICE at any time.

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES for Nance Reynolds LCSW, RN, and I agree to the procedures and policies described therein. Specifically, I agree that my PHI may be used and disclosed by Nance Reynolds to carry out treatment, payment, and health care operations as specified in the NOTICE. (For more information on uses and disclosures, please refer to the NOTICE.) I understand that I have the right to review the NOTICE before signing this consent. I understand that I have the right to request restrictions on the uses and disclosures of my PHI. I also understand that Nance Reynolds LCSW, RN does not have to agree to my requested restrictions, but if she does agree, that agreement is binding. I understand that I can revoke consent in writing, but I cannot revoke consent retroactively.

Client (or personal representative) ____

Client (or personal representative) ____

Date ______________________________

Relationship to Client (if a personal representative) ______________________________________

For Office Use Only

I, Nance Reynolds LCSW, RN, have attempted to obtain written acknowledgment of receipt of the NOTICE OF PRIVACY PRACTICES from the client named above, but acknowledgment could not be obtained because: The client or personal representative refused to sign. Communications barriers prohibited obtaining the acknowledgment. An emergency situation prevented us from obtaining acknowledgment. Other (specify below):

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Nance Reynolds PhD, LCSW