**Notice of Policies and Practices to Protect the Privacy of Your Health Information**

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.

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 these terms, here are some

definitions:

“*PHI*” refers to information in your health record that could identify you.

“*Treatment*, *Payment*, and *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, social

worker, therapist, psychologist, or psychiatrist.

* *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 or to determine eligibility of coverage.
* *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, and case management and care coordination.

“*Use*” applies only to activities within my office, such as sharing, employing, applying,

utilizing, examining, and analyzing information that identifies you.

“*Disclosure*” applies to activities outside of my office, such as releasing, transferring, or

providing access to information about you to other parties.

1. **Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations

when your appropriate 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 counseling

session, which I have kept separate from the rest of your medical record. These notes are given a

greater degree of protection than PHI.

You may revoke all such authorizations (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 that 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.

1. **Uses and Disclosures with Neither Consent nor Authorization**

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

* **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must by law make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
* **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
* **Abuse by a Therapist:** If I have cause to believe that you have been the victim of sexual

exploitation by a mental health professional during the course of treatment**,** I will report this to the appropriate State Examining Board.

* **Health Oversight:** If a complaint is filed against me with the appropriate State Board

overseeing me – The Texas State Board of Examiners of Psychologists, The Texas Board of Medical Examiners, the Texas State Board of Social Work Examiners, or the Texas State Board of Professional Counselors – they have the authority to subpoena confidential mental health information from me relevant to that complaint.

* **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release 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 determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
* **Worker’s Compensation:** If you file a worker’s compensation claim, I may disclose records relating to your diagnosis and treatment to your employer’s insurance carrier.
1. **Patient’s Rights and My Duties**

**Patient’s 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 your request, I will send information to another address.)

* *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 records 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 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 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* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). 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 this notice from me

upon request, even if you have agreed to receive the notice electronically.

**My 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 provide you a revised copy at your next visit or by mail.
1. **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, talk to me about these concerns.

You may also 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.

1. **Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this

notice and to make the new notice provisions effective for all PHI that I maintain. I will provide

you with a revised notice at your next visit or by mail.

**Acknowledgement of Review of Notice of Policies and Practices to Protect the Privacy of Your Health Information**

I have received a copy of this office’s Notice of Policies and Practices to Protect the Privacy of my Health Information, which explains how my health information will be used and disclosed and I have reviewed it.

Description of Personal Representative/Guardian’s Authority

Date

Signature of Patient or Personal Representative/Guardian

Print Name of Patient or Personal Representative/Guardian