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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.

YOUR HEALTH INFORMATION:

This notice applies to the information and records I have about your health, health status, and the services you receive from this practice.

I am required by the Health Insurance Portability and Accountability Act (HIPAA) to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describe your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

- **For Treatment.** Except in emergencies or certain unusual situations (specified in the section below), it is my policy to release your personal health information only with your express written consent. If a situation arises in which you wish me to communicate with another treatment provider quickly and it is not possible for you to provide immediate written consent, oral consent will suffice with the understanding that you will provide me with written consent as soon as it is feasible. Please note that this is a higher level of privacy protection than is currently required under HIPAA or Oregon law and that other treatment providers may have less stringent policies.
- **For Payment**. If you request that services be billed to an insurance company or other third party, I may use and disclose health information about you for the purposes of billing and obtaining payment. This information is generally limited to demographic information needed to identify you (e.g., name, address, date of birth, etc.), your diagnosis, and the dates and types of services you received. If a payer requests more information, such as treatment notes, I will notify you of the request and obtain your written authorization before making such a disclosure.
- **For Health Care Operations**. I may use your personal contact information in order to provide reminder calls or otherwise communicate about appointment scheduling. Please notify me if you do not wish to be contacted about appointments, or if there are restrictions you want to make about such contact.

You may revoke your consent for disclosure of health information at any time by giving me written notice. Your revocation will be effective when I receive it, but it will not apply to any uses and disclosures that occurred before that time.

LIMITS AND EXCEPTIONS TO CONFIDENTIALITY:

In accordance with HIPAA and Oregon state laws, I may use or disclose health information about you **without** your permission for the following purposes:

- **To Avert a Serious Threat to Health or Safety.** Based on professional judgment, I may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** I may be required to disclose health information about you by federal, state or local law. For example, disclosures may be compelled by the Department of Health and Human Services.
- **Lawsuits and Disputes.** If I am subpoenaed to testify in court, my policy is to contact the client before releasing treatment records or other personal information. If the client does not consent to the disclosure of personal information, I may assert privilege on the client's behalf. The court, however, can order me to provide testimony or records, and in such instances I will comply with the court order.
- **Law Enforcement**. I may be required to release health information if required to do so by a law enforcement official in response to a court order, warrant, or summons. If I am subpoenaed to provide records or testify in court, my policy is to contact the client before releasing treatment records or other personal information.
- **Family and Friends.** In situations where you are not capable of giving authorization (because you are not present or due to incapacity or medical emergency), I may, using my professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, I would disclose only the information relevant to the person's involvement in your care. For example, if you were in a mental health crisis, I might involve a family member or friend to help you get to an appropriate care facility.

ADDITIONAL DISCLOSURES THAT MAY OCCUR WHEN YOUR PERSONAL HEALTH INFORMATION LEAVES THIS OFFICE:

Additional disclosures are permitted under HIPAA regulation. These additional disclosures will not be made by this practice without your authorization, and they may be contrary to state law. Be advised, however, that once information leaves this practice and becomes part of an outside data bank, HIPAA permits disclosure in the following circumstances:

- **Payment and Healthcare Operations.** Healthcare information about you can be used by insurance companies or other third party payers for the purposes they

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of all disclosures of your personal health information that were made for purposes other than treatment, payment, and health care operations (e.g., consulting with an attorney). To obtain a copy of this list, you must provide a written request and specify a time period (which may not be longer than six years and may not include dates before April 14, 2003). The first list you request within a 12-month period will be provided at no charge. For additional lists, I may charge you for document retrieval, copying, and mailing.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of it, like a family member or friend. For example, you could ask that we not call you at your office, or that we not communicate with a certain family member, no matter what the circumstances. I usually agree to these requests, but I am not obligated to abide by a request that I feel is unreasonable or incompatible with treatment needs. To request restrictions, you may simply advise me in writing of specific limitations or restrictions you want placed on the use of your health information for treatment.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

IF YOU HAVE A COMPLAINT:

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice, and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date clearly shown at the top. You are entitled to a copy of the notice currently in effect.