

# Northwest Counseling Associates

4257 Gabel Drive, Suite 3A • Fayetteville, AR 72703

## HIPPA PRIVACY NOTICE (Effective 7/15/08)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this information carefully.

### **Protecting Your Personal Health Information**

I value my relationship with you and I am committed to protecting the privacy of your personal and health information I want you to understand how I protect the confidentiality of your personal and health information as well as how I use and disclose it. I am required by state and federal laws to maintain the privacy of your personal and health information. Personal and health information includes any information that is identifiable to you as your personal information including information regarding your health care and treatment, and other identifiable factors such as name, age, address, income, or other financial information.

### **How I Protect Your Personal Information**

- I treat all your personal information as confidential;
- I restrict access to your personal information to only those employees who need to know that information in order to provide services to you;
- I only disclose your personal information to the extent necessary for an insurance company to perform its function on our behalf, and under the condition that the company agrees to protect and maintain the confidentiality of your personal information; and
- I maintain physical, electronic, and procedural safeguards that are in compliance with federal and state regulations to ensure confidentiality of your personal information.

### **HOW I USE AND DISCLOSE YOUR PERSONAL INFORMATION**

When you receive care from my office, I may use your health information for treating you, billing for services, and conducting our normal business. I will only disclose your personal information when I am required or allowed by law, or in the event that you or your authorized representative gives us permission to do so. Uses and disclosures other than those listed below require your authorization. If there are other legal requirements under applicable state laws that further restrict my use or disclosure of your personal

information, I will comply with those legal requirements as well. The following are the types of disclosures that I may make as allowed or required by law:

- **Treatment:** I may use and disclose your personal information for our treatment activities;
- **Payment/Billing:** I may use and disclose your personal information for billing and payment purposes such as claims to insurance companies or Medicaid;
- **Business Associates:** I may also share your personal information with third party business associates who may be contracted to perform certain activities for me. I ask these business associates to treat your information in a manner consistent with HIPPA laws;
- **To You or Your Authorized Representative:** Upon your request, I will disclose your personal information to you or your authorized representative. If you authorize me to do so, I may use your personal information or disclose it to the person or entity you name on your signed authorization. Once you provide me with an authorization, you may revoke it in writing at any time. Your revocation won't affect any use of disclosures permitted by your authorization while it was in effect. In certain situations, when disclosures of your information could be harmful to you or another person, we may limit the information available to you, or use an alternative means of meeting your request;
- **To Your Parent if You are a Minor:** Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and/or persons acting in a similar legal status. I will act consistently with the laws of the State of Arkansas, and will make disclosures consistent with such laws;
- **Your Family & Friends:** If you are unable to consent to the disclosure of your personal information, such as in a medical emergency, I may disclose your personal information to a family member or friend to the extent necessary to help with your health care. I will only do so in the event I feel the disclosure is in your best interest. With your approval, I may disclose/request your personal health information to designated family, friends, and others to assist that person in caring for you or in paying for services rendered to you;
- **Public Health and Safety:** I may disclose your personal information if I believe the disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. I may disclose your personal information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes;
- **Required by Law:** I must disclose your personal information when I am required to do so by law;

- **Process & Proceedings:** I may disclose your personal information in response to a court or administrative order, subpoena, discovery request, or other lawful process, and if required to government oversight agencies conducting the audits;
- **Law Enforcement:** I may disclose limited information to law enforcement officials; and
- **Military & National Security:** I may disclose to military authorities the personal information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials personal information required for lawful intelligence, counterintelligence, and other national security activities.

## **YOUR RIGHTS REGARDING DISCLOSURE AND USE OF YOUR PERSONAL INFORMATION**

- **Access to Your Personal Information:** You have the right to review and receive a copy of your personal information. This right doesn't include the right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding; and protected health information that is subject or other state or federal laws that prohibit me to release such information. I may also limit your access to your personal information if I determine that providing the information could possibly harm you or another person. If I limit access based on the belief that it could harm you or another, you have the right to request a review of that decision;
- **Amendment:** You have the right to request that I amend your personal information. Your request must be in writing, and must identify the information that you think is incorrect and explain why the information should be amended. I will respond to the request in ten business days. I may decline your request for a variety of reasons. If I decline your request to amend your records, I will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you want amended. If I accept your request to amend the information, I will make reasonable efforts to inform others of the amendment and to include the changes in any future disclosures of that information; and
- **Accounting of Disclosures:** You have the right to receive a report of instances in which I, or my business associates disclosed your personal information for purposes other than for treatment, payment, mental health service operations, and certain other activities. You are entitled to such an accounting for the six years prior to your request. I will provide you with the date of which I made a disclosure, the name of the person or entity to whom I disclosed your personal information, a description of the personal information I disclosed, and the reason

for the disclosure. If you request this list more than one time in a 12 month period, I may charge you a reasonable fee for creating and sending these additional reports. This notice takes effect July 15, 2008 and will remain in effect unless revised. I reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. I will notify you of any changes in regard to our privacy practices.

- **Right to request where we contact you**

Home            yes or no

Work            yes or no

Cell phone    yes or no

If not, how may we contact you \_\_\_\_\_

**Acknowledgement of Receipt of HIPPA Privacy Notice**

Client Name:\_\_\_\_\_ Date:\_\_\_\_\_

I acknowledge that I have been given a copy of the HIPPA Privacy Notice. I have reviewed the HIPPA Privacy Notice and have had the opportunity to ask any questions I may have regarding the information presented in the notice. Such questions have been answered to my satisfaction. The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient.

Signature:\_\_\_\_\_ Date:\_\_\_\_\_

Witness Signature:\_\_\_\_\_ Date:\_\_\_\_\_