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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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected health information" (PHI) is information about you, including demographic information that may identify you and relates to your past, present or future physical and mental health or condition and related health care services. If you suspect a violation you may file a report to the appropriate authorities in accordance with Federal regulations.

How I may use and disclose health information about you:

1) Treatment: Your personal health information may be used and disclosed by me for the purpose of providing treatment that is in your best interest. This may include coordinating services with other health care practitioners and/or consultation with other mental health providers.

2) Payment: With your authorization I may use and disclose your PHI so that I am able to receive payment for the services I provide you.

3)With authorization: I will obtain written authorization from you to request information on your behalf, to discuss your treatment with other practitioners and to check eligibility and receive payments from your managed care company. You may revoke your authorization any time in writing.
In the event that I want to use your private health information for purposes of marketing or sales, I will not not do so with out your written consent.

4) Without authorization: The law also allows me to disclose information about you with out your consent in a limited number of situations such as a court order. Other examples are healthcare licensure reports, public health reports and law enforcement reports.

I am obligated by law to make disclosure of your PHI in order to report abuse or neglect. The information that I will disclose will be limited to only that information which is relevant and necessary to make the initial mandated report.

5) **Therapy notes:** I will keep two separate files related to your treatment. One will record treatment dates, amount paid, or billed to insurance and a treatment plan if necessary. I will

not disclose this information with out your written consent. The second will include my personal notes taken in regards to contents of our sessions. I will not disclose any part of the later and it will be used only by me. In the event that disclosure is requested or needed I will only do so with your written permission unless subpoenaed by a court of law.

6) **Marketing and sale:** You have the right to opt out of receiving any sales or marketing or fundraising communications that would come from me or any colleagues of mine.

YOUR RIGHTS REGARDING YOUR PHI:

1)Right to access: You have the right to request access to and/or inspect your PHI in a designated record set. A "designated record set" contains medical and billing records and any other records that I may use to make decisions about you. Your request must be in writing and I may charge you a reasonable fee for copying and transmitting your PHI. I am deny you access to your records under certain circumstances. You may appeal my denial.

2) Right to amend: If you feel that the information I have about you is incorrect, you ay ask to have protected health information in a designated record set amended.

3)Right to an accounting of disclosures: You have the right to receive an accounting of the disclosures made by me of your PHI. I will maintain records after our last treatment session for six years.

4) Right to request restriction: You have the right to request a restriction or limitation on the health information I use or disclose about you for treatment, payment or health car operations. You may request in writing that I not disclose your PHI for the purposes of treatment, payment or to family members involved in your care. I am not required to agree to such restrictions.

5)Right to confidential communications: If you feel that your life may be in danger if I contact you at the address or phone number maintained in my records, you may request that I contact you in a different way or at a different location.

6) Right to a copy of this notice: You have the right to a copy of this notice.

7) Right to restrict disclosure of your private health: if you have paid for your session out of pocket.

8) Right to receive notice: if there has been a breach of your protected health information

9) Complaints: You have the right to file a complaint in writing to me or to the Secretary of Health and Human Services if you believe I have violated your privacy rights**.** ***I will not retaliate against you for filing a complaint.***

I am my own privacy officer. If you have any questions about this Notice of Privacy Practices, please contact me. My contact information is:

2800 E. Madison #205, Seattle, Wash. 98112 Ph: (206) 264-4401

To file a complaint with the Secretary of Health and Human Services, please send correspondence to this address:

200 Independence Ave. S.W.
Washington D.C. 20201
(202) 619-0257

I hereby acknowledge receiving a copy of this notice.

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Patients signature **Date**