THE PSYCHOLOGY CENTER

PRIVACY PROTECTION

We believe that confidentiality is an essential element of effective and respectful treatment. Please be assured that we always have, and will continue, to protect your privacy.

This Notice describes how your Protected Health Information (PHI) may be used or disclosed and how you can examine the information.

Your health record contains personal information about you. This personal information about your treatment and your mental or physical health is referred to as **Protected Health Information (PHI)**. PHI may be written (e.g. treatment record), spoken (therapist consultation), or electronic (billing records.) We would like you to know how we use your PHI and how laws protect this information and your rights to gain access to, grant release of, and correct your PHI.

A federal law (HIPAA) requires us to maintain the privacy of your PHI, to inform you of our legal duties and privacy practices and to follow the privacy practices that we describe. We may need to change our Privacy Practices in the future, but will notify you of any changes in our practices by posting our privacy practices in our waiting room and, if you request, by giving you a copy of the revised privacy practices at your next appointment or through the mail. If we do change our privacy practices, the changes will be effective for all PHI that we maintain at that time. **THIS NOTICE BECAME EFFECTIVE ON SEPTEMBER 23, 2013.**

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be disclosed to those who are involved in your care at our clinic (including clinicians, psychiatrists, staff members, professional trainees, and volunteers) for the purpose of providing, coordinating, or managing your treatment, for example, consultations with Psychology Center psychiatrists or colleagues. We may also exchange medical information with your pharmacy about needed medicine(s).

For Health Care Operations. We may use or disclose your PHI in order to support necessary business activities including quality assessment efforts, licensing requirements, insurance or other audits, and other such business procedures. For example, we may share your PHI with third parties that perform billing or typing services if we have a written contract with the business that requires it to safeguard the privacy of your PHI.

For Payment. With your authorization, we may disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities include determining coverage for insurance benefits and processing claims with your insurance company. If it becomes necessary to use collection processes to obtain payment for services, we will only disclose the minimum PHI necessary to allow for collection.

For Appointments. We may need to remind you of appointments, notify you of changes in your appointments, or leave messages for you about other aspects of your care that may help you to receive needed services. If this contact is made by phone, and you are unavailable, we may need to leave a message on your answering machine or with the person who answers the home or work phone number you have provided. ***(To decline the disclosure of your PHI to assist you in this way, please let us know of your wishes in the appropriate section at the end of this form.)***

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a very limited number of other situations. The types of uses and disclosures that may be made without your authorization include those that are:

- Required by state or federal Law, such as mandatory reporting of child abuse or neglect, mandatory release of information concerning treatment of convicted sexual offenders, and mandatory government agency audits or investigations (for example, Medicare audits or investigations by professional licensing boards or the Department of Health and Family Services).
- Required by lawful Court Order.
- Needed to prevent or lessen a serious and imminent threat to the health or safety of a person, the public, or yourself.
- Required to coordinate treatment for individuals who are being or have been committed to supervision by The Department of Health and Family Services.
- To a licensed physician who has determined that your life or health is in danger and that your PHI is needed to protect your health, with information limited to that needed to meet the medical emergency.

- To a family member (spouse, parent, adult child, or sibling) directly involved in providing your care or monitoring your treatment, if their involvement is verified as necessary by your physician, psychologist, psychotherapist, or other objective party. The information released would be limited to medications, treatment plan, diagnosis, and prognosis and you would be notified of information released (unless you were found to be legally incompetent). Except in an emergency situation, the release of your PHI would require a written request by the family member. If you are receiving or have received treatment for alcohol or drug dependence, release of **ANY** information to family members will be made only with your written consent.

With Authorization. Use and disclosure of your PHI not specifically permitted by applicable law will be made only with your written authorization, which you may revoke in writing at any time except to the extent it has already been acted upon. We will obtain a written authorization from you before we release your PHI in any way not described in this notice, and for the release of psychotherapy notes.

Your Rights Regarding Your Protected Health Information (PHI)

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request **in writing** to our Privacy Officer:

Linda Albert, Client Rights Specialist, 7617 Mineral Point Road, Suite 300, Madison, WI 53717
(608) 833-9290, extension 358 | lalbert@tpcmadison.com

- **Right to Inspect and Copy.** You have a right, which may be limited only in exceptional circumstances (e.g. potential harm to your well-being), to inspect and copy PHI used to plan your care. Psychotherapy notes (therapist notes about details of your session) are given an additional level of privacy protection by law and access may be more restricted. We may charge a reasonable, uniform, cost-based fee for copies.
- **Right to Correct.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. We may not agree to the amendment, but will note your view in the record.
- **Right to a List of Disclosures.** You have the right to request an accounting (list) of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We may not be able to grant your request beyond what the law requires.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Paper Copy of this Notice.** Copies may be obtained at any time upon request from our office.
- **Right to File A Complaint.** If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**
- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.
- **Right to Be Notified if There is a Breach of Your Unsecured PHI.** You have the right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

☐ ***✓ the box if you DO NOT WANT to be contacted by phone or message regarding changes in appointments, reminders of appointments, prescriptions, or other aspects of your care that could help you receive needed services.***

By signing below, I acknowledge I have received, reviewed, and retained a copy of this form.

Patient Name *(please print)* ______________ Date of Birth ______________ Witness ______________

Patient Signature ______________ Parent/Legal Guardian *(please print)* ______________

Date ______________ Parent/Legal Guardian signature ______________