NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. INFORMATION THAT MAY IDENTIFY YOU AND THAT RELATES TO YOUR PAST, PRESENT OR FUTURE MENTAL HEALTH AND RELATED HEALTH CARE SERVICES IS REFERRED TO AS PROTECTED HEALTH INFORMATION.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by me in any form, written, verbally etc. will be kept confidential. At times I may consult with other clinicians regarding your case. This will be done without disclosing any personal information about you unless you have signed a release of information authorizing me to discuss your case.

For Payment Purposes: I may use and disclose your personal health information so that I can receive payment for the treatment services provided to you. This is covered in the Counseling Services Contract. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity or understanding utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services I will only disclose the minimum amount of personal health information needed for purposes of collection.

For Health Care Operations: I may use or disclose your personal health information to support operations of my business. I may share your information with another person who performs various business activities for me such as billing services. I will have a contract with that person or business to insure that your information is protected and that your privacy will be maintained. If, at any time, I would like to use any information regarding your personal information for training purposes it will only be done with your prior authorization.

By law I am required to make disclosures of your personal history information to you upon your request, unless it is determined to be detrimental to your emotional well being. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the privacy rule.

Under the following circumstances I can disclose your personal health information without your authorization. These situations are governed by law and ethical standards.

Abuse & Neglect: By law I have to report suspected abuse and neglect of children, the elderly, and dependent adults.

Minors: If you are under 18 your parents and/or legal guardians can have access to information regarding your treatment. Any exceptions to this policy would be discussed with you and your family.

nic@teaempathy.com • www.teaempathy.com • 760.753.2604 (phone) • 760.632.6859 (fax)
1106 Second Street, #576, Encinitas, CA 92024

Danger: By law I have to notify the appropriate people if you are a danger to yourself or to other people.

Judicial/Administrative Proceedings: I may disclose your protected mental health information in the course of any judicial or administrative proceeding as allowed or required by law, with your specific written consent, or as directed by a Judge's Court Order.

Verbal permission: I may use or disclose your information to family members who are directly involved with your treatment with your verbal permission.

Written Authorization: I may disclose your information to other organizations or individuals involved with your care with your written authorization, which you may revoke at any time.

Your Health Information Rights

You have the following rights regarding your personal health information that is maintained by me. To exercise any of these rights, please submit your request in writing to me.

Request of access to inspect and copy. You have the right to access your information that will be used in making decisions about your care. Your right to inspect and copy your mental health and billing records will be restricted only in those situations where there is compelling evidence that access would cause you serious harm. I may charge a reasonable, cost & time-based fee for copies.

Right to amend: If you feel that information that I have about you is incorrect or incomplete, you may ask to amend the information, but I am not required to agree to the **amendment.**

Right to know when the information has been disclosed: You have the right to request an accounting of the disclosure I make of your personal health information.

Right to request restrictions: You have the right to request a restriction or limitation on the use or disclosure of your personal information for treatment, payment or health care operations. I am not required to agree with your request.

Right to request confidential information: You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

If you are the parent or legal guardian of a minor, please note that certain portions of the minor's mental health record will not be accessible to you

Right to revoke previous authorizations of release of information, except to the extent information or action has already been taken.

If you believe I have violated your privacy rights you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Ave. SW, Washington DC, or by calling 202-619-0257. **I will not retaliate against you for filing a complaint.**

I do not have a secure system for receiving email or text messages. If you do send me email, know that this information is not encrypted and could be accessed by a hacker. If you want to insure that all communication is confidential communicate by phone to 760-753-2604. In order to ensure that faxes are confidential please contact me by phone prior to sending a fax to fax number 760-632-6859.

Client signature: ________________________________ Date:___________________

Therapist signature: ________________________________Date:___________________