HIPAA Notice of Privacy Practices

HIPAA (Health Insurance Portability Act) is a Federal Law Enacted in 1996

RADIANCE Counseling, PLLC

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.

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care and mental health care services.

USES AND DISCLOSURES OF YOUR (PHI) PROTECTED HEALTH INFORMATION (WITH OR WITHOUT CLIENT WRITTEN CONSENT):

In General: Your protected health information (PHI) may be used and disclosed by me, your therapist, and others outside of my office that are involved in your care and treatment for the purpose of providing mental health services to you, to pay your mental health care bills, to support the operation of the therapist's practice, and any other use required or permitted by law.

Treatment: I may use and disclose your PHI to provide, coordinate, or manage your mental health care and any related services. This includes the coordination or management of your health care with a third party health care provider. For example, I may disclose your PHI, as necessary, to a third party provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you. Note: my practice is to have you sign a Release of Information form in these instances.

Payment: Your PHI may be used, as needed, to obtain payment for your mental health care services. For example, obtaining approval for counseling services may require that you're relevant PHI be disclosed to the health plan to obtain approval, or payment, for treatment.

Healthcare Operations: I may use or disclose, as needed, your PHI in order to support the business activities of my therapy practice. These activities may include, but are not limited to, quality assurance activities, licensing, and conducting or arranging for other business activities. For example, I may disclose your PHI, as necessary, to contact you to remind you of your appointment.

Without Client Authorization: I may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues (as required by law), Abuse or Neglect, Legal Proceedings (when issued a court order by a judge for information related to your records or treatment), Law Enforcement, and Danger to Self or Others. Under the law, I must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine my compliance with the requirements of Section 164.500. Other permitted and required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclose indicated in the authorization.

YOUR RIGHTS UNDER THE FEDERAL HIPAA LAW THE FOLLOWING IS A STATEMENT OF YOUR RIGHTS WITH RESPECT TO YOUR PHI (PROTECTED HEALTH INFORMATION):

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. The information is available up to seven years from the date that the record was created. Your request to inspect or obtain a copy of the file must be in writing. There will be a charge of $.20 per page copied

You have the right to request a restriction of your PHI. This means you may ask me not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state in writing the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If the therapist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Mental Healthcare Professional.

You have the right to request to receive confidential communications from me by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to have your therapist amend your PHI. If I deny your request for amendment, you have the right to file a statement of disagreement with me and I may prepare a rebuttal to your statement and will provide you with a copy of any such material.

You have the right to receive an accounting of certain disclosures I have made, if any, of your PHI.

I reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may make a complaint directly or to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. We respect your right to file a complaint and I will not retaliate against you for filing a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services: 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

This notice was published and became effective on/or before APRIL 14, 2003.

I am required by law to maintain the privacy of, and provide individuals with, this notice of my legal duties and privacy practices with respect to PHI. If you have any concerns about this notice, please speak with me directly. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

Client Name (Printed): _____ Date: _____

Your signature: _____ Date: _____

Reviewed by: _____ Date: _____

Clinician's Signature