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Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask me to limit the information I share
- Get a list of those with whom I've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

I may use and share your information so I can:

- Treat you
- Run my organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information I have about you. Ask me how to do this.
- I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this.
- I may say "no" to your request, but I'll tell you why in writing within 60 days.

Request confidential communications

- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- I will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or our operations with your health insurer. I will say "yes" unless a law requires me to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why.
- I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). I'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- I will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel I have violated your rights by contacting me using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- I will not retaliate against you for filing a complaint.
- I am licensed in Washington State as a LMHCA, **License Number** MC60693152.

Your Choices

For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, talk to me. Tell me what you want me to do, and I will follow your instructions.

In these cases, you have both the right and choice to tell me to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if I believe it is in your best interest. I may also share your information when needed to lessen a serious and imminent threat to health or safety.

Uses and Disclosures

How do I typically use or share your health information?

I typically use or share your health information in the following ways.

Treat you. I can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run my practice. I can use and share your health information to run my practice, improve your care, and contact you when necessary. This includes consulting with the supervisors overseeing my practice for licensing and professional training purposes.
Example: I use health information about you to manage your treatment and services.

Bill for your services. I can use and share your health information to bill and get payment from health plans or other entities. *Example: I give information about you to your health insurance plan so it will pay for your services.*

How else can I use or share your health information?

I am allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. I have to meet many conditions in the law before I can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

I can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research. I can use or share your information for health research.

Comply with the law. I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I am complying with federal privacy law.

Respond to organ and tissue donation requests. I can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. I can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. I can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions. I can share health information about you in response to a court or administrative order, or in response to a subpoena.

My Responsibilities

- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

I can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice is May 1, 2018
- The privacy contact person is: Julia Fay, at the contact information above.
  Email: Julia.fay@strongheartthealingcenter.com
- I never market or sell personal information.
- The Privacy Rule requires that I describe Washington State laws that may invoke limits on confidentiality or disclosure of information. Those laws are described in the disclosure form that accompanies this Notice. In short, I am required by State law to disclose information regarding the abuse or neglect of a child or of a vulnerable adult. I have a duty to warn / protect others, if I believe that the client poses foreseeable risk to him/herself or others, whether or not a client has communicated an actual threat of physical harm against an identifiable person. Disclosure of PHI may be required by subpoena or court order. Disclosure to any person may be permitted if we have a reasonable belief that doing so will avoid imminent danger or harm to any person.

ACKNOWLEDGMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES

I, _____
(print client name)

or the parents or legal guardian of the patient

_____
(print parent, guardian, or other representative name)

_____
(relationship to child)

acknowledge here that I have reviewed and been offered a copy of Notice of Privacy Practices

_____ _____

Signature of Patient (or Parent, Representative, or Legal Guardian) Date

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Below Section To Be Completed By SHHC

If acknowledgment of receipt has not been obtained:

I _____ (print name of health care provider) hereby state that I made a good faith effort to obtain client's acknowledgment of receipt of the Notice of Privacy Practice and Disclosure Form. I also indicate here the reason why the acknowledgment was not obtained:

___ client refusal

___ other:

_____

(signature of health care provider) Date