



## **Health Insurance Portability Accountability Act (HIPAA) 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 IT CAREFULLY.**

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document.

### **AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

The law protects the privacy of all communication between a client and therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. If you authorize me or this Practice to use or disclose your health information, you may revoke that authorization in writing at any time. A revocation of authorization will be effective on the date it is received and will not affect previous disclosures.

### **LIMITS ON CONFIDENTIALITY**

There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, including audits and investigations.
3. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.



4. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. In the event your therapist is incapacitated, or an interruption of services occurs such as illness, mental or physical ability or death, a named professional executor will act on behalf of your therapist to ensure continuity of your care and treatment.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Iowa Department of Human Services Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Iowa Department of Human Services Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the client.

## **CLIENT RIGHTS AND THERAPIST DUTIES**

### **Use and Disclosure of Protected Health Information:**



- **For Treatment** – I use and disclose your health information internally during the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- **For Payment** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Consent for Therapy Services, Policies, and Agreement form.
- **For Operations** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality.

#### **Client's Rights:**

- **Right to Treatment** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender, gender identity, sexual orientation, religion/spirituality, disability status, age, marital status, immigration status, socioeconomic status, or any other protected category.
- **Right to Confidentiality** – You have the right to have your health care information protected.
- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- **Right to Choose How I Send PHI to You** – You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of \$1.00 per page. Please make your request in writing well in advance and allow 30 days to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- **Right to Amend** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You must make this request in writing. You must tell us the reasons you want to make these changes. If I refuse to make the amendment, I will tell you why within 60 days.
- **Right to a Copy of This Notice** – If you received the paperwork electronically, you have a copy in your email. Even if you have agreed to receive this Notice of Privacy Practices via email, you also have the right to request a paper copy of it.
- **Right to Accounting of Disclosures** – You have a right to receive an accounting of disclosures of your health information made by me in the six years prior to the date of your request. The request for an accounting must be made in writing to the Privacy Officer identified below. We will provide the first accounting during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.
- **Right to Choose** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.



- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone or email letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether I think releasing the information in question to that person or agency might be harmful to you.

#### **Therapist's Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our sessions.
- We are required to provide you with notification if we discover a breach of your unsecured protected health information that may have compromised the privacy or security of your information. You will be notified without unreasonable delay and no later than 60 days after discovery of the breach. Such notification will include information about what happened and what can be done to mitigate any harm.

#### **COMPLAINTS**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at (319) 214-3450, the State of Iowa Department of Human Services, or the Secretary of the U.S. Department of Health and Human Services 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/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).

There will be no retaliation for filing a complaint.

#### **EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on 01.20.2023

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES.

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Print Client's Name

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Date

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Signature of Client/Parent/Legal Guardian

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Relationship