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HIPAA Privacy Authorization Form Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)
The Health Insurance Portability and Accountability Act (HIPAA) establishes patient rights and protections associated with the use of protected health information. HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care providers. Providers and health care agencies are required to provide patients a notification of their privacy rights as it relates to their health care records.

This Patient Notification of Privacy Rights informs you of your rights. Please carefully read this Patient Notification. It is important that you know and understand the patient protections HIPAA affords you as a patient.

In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; therefore, I will do all we can do to protect the privacy of your mental health records. If you have questions regarding matters discussed in this Patient Notification, please do not hesitate to ask.

I. Preamble

Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA clearly defines what kind of information is to be included in your "designated medical record" or "case record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers. HIPAA provides privacy protections about your personal health information, which is called "protected health information (PHI)" which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations.

Treatment refers to activities/sessions I provide, coordinate or manage your mental health care service or other services related to your health care. Examples include a counseling session or communication with your primary care physician about your medication or overall medical condition.

Payment is when Hillary Schultz Therapy, LLC obtains reimbursement for your mental health care or other services related to your health care.

Health care operations are activities related to my performance such as quality assurance. The use of your protected health information refers to activities my counseling practice conducts for scheduling appointments, keeping records, and other tasks related to your care. Disclosures refer to activities you authorize such as the sending of your protected health information to other parties (i.e., your insurance company).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

If you request Hillary Schultz Therapy, LLC to send any of your protected health information of any sort to anyone outside my office, you must first sign a specific authorization to release information to this outside party. A copy of that authorization form is available on the website and upon request. In recognition of the importance of the confidentiality of conversations between therapist and patients in treatment settings, HIPAA permits keeping "psychotherapy notes" separate from the overall "designated medical record". "Psychotherapy notes" are the therapist's notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, or joint family counseling session and that are separated from the rest of the individual's medical record." "Psychotherapy notes" are private and contain information about you and your treatment.

III. Uses and Disclosures Not Requiring Consent or Authorization

By law, protected health information may be released without your consent or authorization under the following conditions:

- Suspected or known child abuse or neglect
- Suspected or known sexual abuse of a child
- Adult and Domestic abuse
- Suspected or known abuse of an older adult/elderly person
- Suspected or known abuse of someone developmentally or cognitively disabled
- Judicial or administrative proceedings/Court order signed by a judge (i.e. you are ordered here by the court)
- Serious threat to health or safety (i.e. "Duty to Warn" and Threat to National Security)

V. Patient's Rights and Our Duties

You have a right to the following:

• The right to request restrictions on certain uses and disclosures of your protected health information which I may or may not agree to but if I do, such restrictions shall apply unless our agreement is changed in writing.

• The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want forms mailed to your home address so I will send them to another location of your choosing.

• The right to inspect and copy your protected health information in the designated record and any billing records for as long as protected health information is maintained in the record.

• The right to insert an amendment in your protected health information, although the therapist may deny an improper request and/or respond to any amendment(s) you make to your record of care.

• The right to an accounting of non-authorized disclosures of your protected health information.

• The right to a paper copy of notices/information from Hillary Schultz Therapy, LLC, even if you have previously requested electronic transmission of notices/information.

• The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask for further assistance on these matters.

Hillary Schultz Therapy, LLC is required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and our duties regarding your PHI. Hillary Schultz Therapy, LLC reserves the right to change its privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of these policies when you come for future appointment(s). My duties in these matters include maintaining the privacy of your protected health information, to provide you with a notice of your rights and our privacy practices with respect to your PHI, and to abide by the terms of the notice unless it is changed and you are so notified.

VI. Complaints

The right to have oral or written instructions for filing a grievance. The right to file a grievance is not time limited. If you need assistance in filing a grievance or want further information, please contact:

Ohio Counselor, Social Worker & Marriage and Family Therapist Board
77 S High St., 24th Floor, Rm 2468
Columbus, OH 43215-6171
(614) 466-0912 http://cswmft.ohio.gov

Please print, sign, and date this form below to acknowledge that you have familiarized yourself with Confidentiality/HIPAA practices.

I _____,

(Patient/Guardian if a minor), have either downloaded or have been provided a copy of The Patient Notification of Privacy Rights.

My signature below indicates that I had opportunity to review this document prior to signing it.

Patient/Guardian Signature:_____

Date: _____

Therapist Signature: _____

Date: _____