

Notice of Privacy Practices

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This document describes how healthcare information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

The purpose of this document:

Both State and Federal law require me to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected health Information" or "PHI"). If you ever have any questions about my privacy practices, please ask me. Additional copies of this Notice can be obtained through my website: www.treinaaronson.com.

Uses and Disclosures of Protected Health Information (PHI):

I hold confidentiality as an essential aspect of our work together. I cannot and will not disclose any information from your sessions, including the fact that you are or have been a therapy client without your written consent. If you provide written consent you maintain the right to revoke that permission. The possible legal exceptions to this policy are listed below:

- Permissible uses and Disclosures without Your Written Authorization
 - a) I may use or disclose PHI when I am required or permitted to do so by law. Examples include:
 1. Where there is reason to suspect the occurrence of abuse or neglect of a child, a dependent adult, or a developmentally disabled person
 2. Where there is a clear threat to do serious bodily harm to yourself or others
 3. In a response to a subpoena issued by the Secretary of health that is associated with a regulatory complaint
 4. Disclosures for public health activities
 5. Disclosures related to communicable diseases
 6. Health oversight activities including disclosures to state or federal agencies authorized to access PHI
 7. If you are involved in some legal action, it is possible a court order might require I provide the court with evidence relating to your therapy
 8. Disclosures for research when approved by an institutional review board
 9. Disclosures to military or national security agencies, coroners, medical examiner, and correctional institutions
 10. In the event of an emergency, emergency personnel or service providers may be given necessary information
 11. In the event of the client's death or disability, information may be released if the client's personal or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure
 12. In the event you reveal the contemplation or commission of a crime or harmful act
 13. For auditing purposes or state licensing review or as otherwise authorized by law
- Uses and Disclosures Requiring Your Written Authorization
 - a) A signed authorization is needed before disclosing information for purposes of treatment, payment and/or operations.
 - b) I do keep psychotherapy notes. These notes will only be used by me and will not otherwise be used or disclosed without your written authorization.

- c) I will not use your PHI for marketing or fundraising communications without your written consent.
- d) Uses and disclosures other than those described above will only be made with your written authorization. For example, you will need to sign an authorization form before I could send PHI to your attorney. You may revoke any such authorization at any time.

Your Individual Rights:

- **Right to inspect and copy:** You may request access to your medical and billing records maintained by me in order to inspect and request copies of these records. All requests must be made in writing. Under limited circumstances, I may deny access to your records if I believe the information may be harmful to you or someone else. You have the right to appeal any denials. I may charge a fee for the costs of copying and sending you any requested records.
- **Right to alternative communication:** You may request, and I will accommodate, any reasonable written request for you to receive alternative means of communication or at alternative locations.
- **Right to request restrictions:** You have the right to request restrictions on certain uses and disclosure of your healthcare information I use for treatment, payment or operations. For example, you may determine what, not all of your information I communicate to your physician. As a treating clinician, I am legally obligated to agree to your request, yet if I believe sharing this information is required for optimum care, I would want us to make a mutual decision on how to proceed.
- **Right to request amendment:** You have the right to request I amend your health care information. Your request must be in writing and I may deny your request under certain circumstances.
- **Right to obtain notice:** You have the right to obtain a copy of this Notice by contacting me directly or through accessing my website at www.treinaaronson.com
- **Question and complaints:** If you believe I have violated your privacy rights, you may file a complaint in writing with me, and/or with the Secretary of the Department of Health. I will not retaliate against you for filing such a complaint. You may contact the Dept of Health at 360-236-4700, or by writing to Washington State Department of Health, Health Systems Quality Assurance, PO Box 47850, Olympia, WA 98504-7850. You can access information on acts of unprofessional conduct online at: <http://www.legal.wa.gov/wsladm/rcw.htm>. You may also file written complaints with the Director, Office for Civil Rights of the US Department of Health and Human Services.

Effective Date: This notice is effective August 1, 2008 and revised August 6, 2009

Changes to this Notice:

- I am required by law to abide by the terms of this document, though I am also legally allowed to change the terms, and to make the provisions of any modified version effective for all healthcare information in my care. You may request that a modified version be given to you or you may access a current electronic version through my website: www.treinaaronson.com

I have had an opportunity to review this document and have my questions, if any, answered. My signature below represents I have read, understood, and have been provided with a copy of the above Notice of Privacy Practices.

Client Signature

Date

Client Signature

Date

Treina Aronson, LMHC

Date

