Paul D. Connor, Ph.D.

Notice of Policies and Practices to Protect the Privacy of Your Health Information in the State of Washington

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations.

I may use or disclose your *protected health information (PHI)*, for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions.

- *"PHI"* – refers to information in your health care record that could identify you.
- "Treatment, Payment, and Health Care Operations"
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of such treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
    - *Payment* is when I obtain reimbursement for your health care. Examples of payment are when I disclose you PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* – applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* – applies to activities outside of my offices such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for the purposes outside of treatment, payment and health care operation, I will obtain authorization from you before releasing this information. I will also need to obtain authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private or joint session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that 1) I have relied on that authorization; or 2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosure with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it immediately to the proper law enforcement agency or the Washington Department of Social and Health Services.
- **Adult and Domestic Abuse:** If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must immediately report the abuse to the Washington Department of Social and Health Services. If I have reason to suspect sexual or physical assault has occurred, I must immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.
- **Health Oversight:** If the Washington Examining Board of Psychology subpoenas me as part of its investigations, hearings or proceedings related to the discipline, issuance or denial of licensure of state licensed psychologists, I must comply with its orders. This could include disclosing your relevant mental health information.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** I may disclose your confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.
- **Worker's Compensation:** If you file a state worker's compensation claim, with certain exceptions, I must make available, at any stage of the proceedings, all mental health information in my possession relevant to that particular injury in the opinion of the Washington Department of Labor and Industries (L&I), to your employer, your representative, and L&I.

IV. Patient's Rights and My Duties

Patient's Rights:

- **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.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communication of PHI by alternative means at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss the details of the request and denial process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice from me upon request even if you have agreed to receive the notice electronically.

My 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 ad 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 let you know at the time of your next appointment or by mail.

V. 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 or you can send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The agency listed above can provide you with the appropriate address upon request.

This notice was published and first became effective on April 14, 2003.

Patient Name _____

Patient Signature_____ Date_____

Patient/Responsible Party Signature_____ Date_____

Print Signature_____