

## NOTICE OF PRIVACY PRACTICES OF

Ruth Weinberg LPC  
1726 Clarkson Street, Denver, Colorado 80218  
ruth@ruthweinberg.com  
720.432.1163

Effective April 14, 2003

**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. IF YOU HAVE ANY QUESTIONS OR REQUESTS ABOUT THIS NOTICE, PLEASE ASK.**

My practice is required by state and federal law to maintain the privacy of protected health information, to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the attached written acknowledgement that you received a copy of this notice. This form also describes your rights regarding your protected health information and how you may exercise your rights.

Protected Health Information, PHI, is information the practice has created or received about your physical or mental health condition, the health care we provide to you or the payment for your health care, and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

#### **Permissible Uses and Disclosures Not Requiring Your Written Authorization**

*Your mental health information may be used and disclosed in the following ways.*

**Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals.

**Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent, to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.

**Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.

**Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

**Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

**Crimes on the Premises or Observed by the Provider:** Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.

**Business Associates:** Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting

with outside entities to perform those services. In those situations, protected health information will be provided to those

Contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

**Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

**Family Members:** Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.

**Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

## **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION - Continued**

### **Uses and Disclosures Requiring Your Written Authorization or Release of Information**

*Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.*

**Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

## **YOUR RIGHTS AS A CLIENT**

**Additional Restrictions:** You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form for Protected Health Information.

**Alternative Means of Receiving Confidential Communications:** you have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

**Access to Protected Health Information:** You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form for PHI and the appeal process.

**Amendment of Your Record:** You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form PHI and the appeal process available to you.

**Accounting of Disclosures:** You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

**Right to Revoke Consent or Authorization:** You have the right to revoke your consent or authorization to use or

disclose your mental health information, except for action that has already taken place under your consent or authorization.

**Copy of This Notice:** You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all Protected Health Information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person that is designated within the Practice to receive your complaints, that is your clinician. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

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**Acknowledgement of Receipt of Notice of Privacy Rights**

I, \_\_\_\_\_, acknowledge that I received a copy of the Notice  
Client Name

of Privacy Practices for Ruth Weinberg, MS, LPC.

\_\_\_\_\_  
Signature of Client or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If not the client, please print name and state legal authority to sign for client.

----- For Practitioner Use Only -----

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:

\_\_\_\_\_ Individual Refused to Sign  
\_\_\_\_\_ Communications Barriers Prohibited Obtaining Acknowledgement  
\_\_\_\_\_ Client Was Incapable of Signing  
\_\_\_\_\_ Other (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

*HIPPA: Notice of Privacy Practices Signature Page*