HIPPA AND WASHINGTON STATE PRIVACY NOTIFICATION

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NOTICE OF POLICIES AND PRACTICES
TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION
Effective date 01/30/2016

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.

My commitment to your privacy:

It is my legal duty to maintain the privacy of your personal health information (PHI) and ePHI (protected health information in electronic form). These laws are complicated, but I must provide you with this information. This is a shorter version of the full, legally required Notice of Privacy Practices (NPP).

I will use the information about your health, which I get from you or from others to provide you with treatment or to arrange payment for my services.

If you or I want to use or disclose (send, share, release) your information for any other purpose, I will discuss this with you and ask you to sign an Authorization to allow this.

Under Federal and State Laws, information about you can be disclosed without your consent in the following circumstances:

1. Emergencies: In case of an emergency, and if you are unable to give or refuse permission, I will share only the information that is directly necessary for obtaining emergency care for you, according to my professional judgment.
2. Danger to Self and/or Others: Information may be disclosed if you are a danger to yourself or others. I may disclose information to the appropriate authorities if I reasonably believe such disclosure is necessary to protect you or a third party from a clear imminent risk of serious physical or mental injury, disease or death.
3. Abuse or Neglect: Information about you may be disclosed to the appropriate authorities, if I have a reasonable basis to believe that abuse or neglect may have occurred.
4. Rights of Your Minor Child: If I am seeing your child in therapy, the same privacy practices will apply except that we will report regularly to you regarding the progress of our work. If your minor child is 13 or older, your child will need to provide their consent for me to report to you.
5. As Required By Law: I must disclose information if required to do so by a court order or by the Washington State Department of Licensing. I will disclose information needed for any legal defense if charges of malpractice are brought against me.

NOTICE OF POLICIES AND PRACTICES

TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION (continued)

Your rights regarding your health information:

- You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

Your rights regarding your health information continued:

- You have the right to ask me to limit what I tell certain individuals involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, an emergency, or if the information is necessary to treat you.

- You have the right to look at the health information I have about you such as your medical and billing records. You can get a copy of these records but I may charge you. Contact me to arrange how to see your records.

- If you believe the information in your records is incorrect or incomplete, you can ask me to make some changes (called amending) to your health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes.

- You have the right to a copy of this notice.

- You have a right to file a complaint if you believe your privacy rights have been violated. I am the designated Privacy/Security official for my practice, you can file a complaint with me, and with the U.S. Department of Health and Human Services Office for Civil Rights. Their address: 200 Independence Ave. SW, Washington DC 20201. My contact information is at the top of this form. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

- You have a right to revoke this consent in writing, except to the extent that I have already taken action on it.

- If you do not sign this consent form agreeing to what is in my Notice of Policies and Practices to Protect the Privacy of Your Health Information, I cannot treat you.

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION (continued)

If you have any questions regarding this notice, my health privacy policies or how to get a copy of your records, please contact me at 206.794.1661.

By signing below you confirm that you have read the material in this Notice.

_____	_____	_____
Signature/Guardian Signature	Name (please print)	Date
_____	_____	_____
Signature/Guardian Signature	Name (please print)	Date
_____	_____	
Therapist Signature	Date	