Amy Gray, LICSW (413) 522-4903
70 Main St., Northampton, MA 01060 amyg.49@verizon.net

HIPAA Notice of Privacy Practices

I am required to tell you about privacy because of a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires me to keep Protected Health Information (PHI) private and to give you this notice about my legal duties and my privacy practices.** I will obey the rules described in this notice.

I. Use and disclosures for *treatment*, *payment* and *health care operations*

I may *use* or *disclose* your *protected health information* (PHI) for treatment and health care operations purposes with your *consent*.

- "PHI" refers to information in your chart that could identify you.
- "Treatment, payment and healthcare operations"
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment is when I consult with another health care provider, such as your PCP or another therapist.
    - *Payment* is when I obtain reimbursement for your health care. Examples of payment are when I disclose your 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 operation and performance of my practice. Examples are quality assessment and improvement activities, business-related matters such as audits, case management, case coordination and administrative services.
    - *Use* applies to activities within my practice, such as sharing, employing, applying examining, utilizing and analyzing information that identifies you.
    - *Disclosure* applies to activities outside my practice, 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 purposes outside of payment, treatment and health care operations, I will obtain written authorization from you before releasing any information. I will also need to obtain a written release before releasing your psychotherapy notes. *Psychotherapy notes* are notes I have made about our conversation during a private, group, family, or joint counseling session, which I have kept separate from the rest of your chart. These notes are given a greater degree of protection than PHI. It is my policy not to keep separate psychotherapy notes. All documentation I keep is a part of your clinical chart.

I will also obtain written authorization from you before using or disclosing PHI in a way that has not been described in this notice.

I will not use your PHI for marketing or sales purposes under any condition.

III. Uses and Disclosures with Neither Consent or Authorization

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

- **Child abuse**: If I, in my professional capacity, have reasonable cause to suspect that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, I am mandated to immediately report such a condition to the Massachusetts Department of Children and Families.

- **Elder Abuse:** If I have reasonable cause to believe that an elderly person (age 60 or older) is suffering or has died as the result of abuse, I must immediately make a report to the Massachusetts Department of Elder Affairs.

- **Health Oversight**: The Board of Registration that applies to my particular type of license to practice has the power, when necessary, to subpoena relevant records, should I be the focus of an inquiry.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative, 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 this case.

- **Serious Threat to Health or Safety**: If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you to have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.

- **Worker's Compensation**: If you file a worker's compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

When the use and disclosure without your consent or authorization is allowed under sections of Section 164.512 of the Privacy Rule and the state's confidentiality law, this includes certain narrowly defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease of FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Mental Health Clinician's 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 alternative locations:** You have the right to request and receive confidential communications of PHI by alternative means and 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 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 the decision reviewed. On your request, I will discuss with you the details of the amendment 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).

- **Right to a paper copy**: You have the right to obtain a paper copy of this notice from me on request, even if you have agreed to receive this notice electronically.

- **Right to restrict disclosures when you have paid for your care out-of-pocket:** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket or in full for my services.

- **Right to be notified if there is a breach in your unsecured PHI:** You have a right to be notified if: (a) there is a breach (a use or disclosure of PHI in violation of HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Mental Health Clinician's 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 and 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 notify current clients and

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 at the office address, phone number or email address. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date and Changes to Privacy Policy

This notice will go into effect January 1st, 2020. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will notify current clients of changes in person or by mail and closed client cases can, if interested, call and ask if our policies have changed and obtain a copy by mail or view one online.

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HIPAA Notice of Privacy Practices - SIGNATURE PAGE

This form is an agreement between you (the client) _____ and Amy Gray, LICSW. When we use the word "you" below it will mean you, your child, relative, or other person if you have written her/his name here.

When I assess, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions**.**

By signing this form you are agreeing that you have read and understand the **HIPAA Notice of Privacy Practices** and you are agreeing to allow me to use your information and to send it to others in accordance with our written policies. *Please make sure you have read and understand my Privacy Policies above before signing this Consent form.*

If you do not sign this consent form agreeing to what is in my HIPAA Notice of Privacy Practices, I will not be able to work with you.

In the future I may change how I use and share your information and so may change my **HIPAA Notice of Privacy Practices**. If I do change it, you can get a copy from my website: www.amygraytherapy.com or by calling me at 413-522-4903.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on.

Name of Client (print):_____

Signature of Client (if over 18 years of age):_____

Signature of Parent/Guardian (if under 18 years of age): _____

Date: _____