JANUARY MASSIN, PH.D.

Licensed Clinical Psychologist (NYS License # 019588)

81 Irving Place, Suite 1B

New York, NY 10003

HIPPA NOTIFICATION

Effective Date

Privacy Officer

January Massin, Ph.D.

Introduction

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires mental health professionals to issue this official Notice of Privacy Practices. This notice describes how information about you is protected, the circumstances under which it may be used or disclosed and how you may gain access to this information. Please review it carefully.

For psychotherapy to be beneficial, it is important that you feel free to speak about personal matters, secure in the knowledge the information you share will remain confidential. You have a right to the confidentiality of your medical and psychological information, and this practice is required by law to maintain the privacy of that information. The practice is required to abide by the terms of Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health and psychological information. If you have any questions about this notice, please contact the privacy officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other professionals at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, (e.g. a billing service) sites and locations at this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except when treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

Uses and Disclosures for Treatment, payment and Health Care Operations

I may use you Protected Health Care Information (PHI) for treatment, payment and health care operation purposes. The following should help clarify these terms:

- PHI refers to information in your health record that could identify you. For example, it may include your name, the fact that you are receiving treatment here, and other basic information pertaining to your treatment, and other basic information pertaining to your treatment.

- Use applies only to activities within my office and practice group, such as sharing, employing, applying, utilizing and analyzing information that identifies you.

- Disclosure applies to activities outside my office and practice, such as releasing, transferring or providing access to information about you to other parties.

- Authorization is your written permission to disclose confidential health information. All authorizations to disclose must be made on a specific and required form.

- Treatment is when I provide, coordinate, or manage your healthcare, and other services related to your healthcare.

- For example, with your written authorization, I may provide your information to your physician to ensure the physician has the necessary information to diagnose or treat you.

- Payment. You PHI may be used, as needed, in activities related to obtaining payment for your health care services. This may include the use of a service or providing you documentation of your care so that you may obtain reimbursement from your insurer.

- Health Care Operations are activities that are related to the performance and operation of my practice. I may use or disclose, as needed, your protected health information in support of business activities. For example, when I review an administrative assistant's performance, I may need to review what that employee has documented in your records.

Written Authorization to Release PHI

Any other uses and disclosures of your PHI beyond those above listed will be made only with your written authorization, unless otherwise permitted or required by law as described. You may revoke your authorization at any time, in writing.

Use and Disclosure without Authorization

The Ethics Code of the American Psychological Association, New York State law, and the federal HIPAA regulations all protect the privacy of all communications between a client and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written authorization. This authorization will be in effect for a length of time you and I determine. You may revoke the authorization at any time unless I have taen action in reliance on it. However, there are

some disclosures that do not require your Authorization. I may use or disclose PHI without your consent in the following circumstances:

- Child abuse if I have reasonable cause to believe a child may be abused or neglected, I must report this belief to the appropriate authorities.
- Adult or Domestic abuse. If I have a reason to believe that an individual such as an elderly or disabled person protected by state law has been abused, neglected, or financially exploited, I mist report this to the appropriate authorities.

- Health Oversight Activities. I may disclose your PHI to a health care oversight agency for oversight activities required by law, including licensure or disciplinary actions. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for information by any party about your treatment and the records thereof, such information is privileged under state law and is not to be released without a court order. Information about all other psychological services (e.g. psychological evaluation) is also privileged and cannot be released without your authorization 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 must be informed in advance if this is the case.

- Serious Threat to Health or Safety: If you communicate to me a specific threat of imminent harm against another individual or if I believe there is clear, imminent risk of injury being inflicted against another individual, I may make disclosures that I believe are necessary in order to protect that individual from harm. If I believe at present there is an imminent, serious risk of serious injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

- Worker's Compensation: I may disclose PHI about you as authorized by and to the extent necessary to comply with laws related to workers compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

<u>Special Authorizations</u>

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

- Psychotherapy Notes. I will obtain a special authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection that PHI.

- HIV information. Special legal protections apply to HIV/AIDS related information. I wil obtain a special written authorization before releasing information related to HIV/AIDS.

- Alcohol and Drug Use Information. Special legal protections apply to information related to alcohol and drug use and treatment. I will obtain a separate written consent from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations (of PHI, psychotherapy notes, HIV information and/or Alcohol and Drug Use information) at any time, provided each revocation is in writing, signed by you and signed by a witness. 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, law provides the insurer the right to contest the claim made under the policy.

Patients' Rights

- Right to request restrictions. You have the right to request restrictions on certain uses/disclosures of PHI. However, I am not required to agree to this request.

- Right to receive confidential communications through alternative means. You have the right to request and receive confidential information by alternative means and locations. (For example, you may not want a family member to know that you are seeing me. On your request I will send your bills to another address.

- Right to inspect and Copy. You have a right to inspect or obtain copy of PHI in my records as these records are maintained. In such cases, I will discuss with you the process involved.

- Right to Amend. You have a right to request an amendment of PHI for as long as it is maintained in the record. I may deny your request. If so, I will discuss with you the details of the amendment process.

- Right to an Accounting. You generally have the right to an accounting of all disclosures of PHI. I can 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 of privacy practices from me upon request.

Psychologists' 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 you at our next session, or by mail at the address you provided me.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, have received a copy of this offices' notice of privacy practices.

Patient Name: _____

Signature: _____ Date:_____