Julie Davis, PhD

Licensed Clinical Psychologist
(716) 939-1438

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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 and billing records 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 treatment would be when I consult with another health care provider, such as your family or primary care physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. 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 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 care 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 which reach outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- *"Consent"* applies to a form you must sign before I begin to treat you.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations only when your authorization is obtained. An *"authorization"* is written permission above and beyond the general consent. It permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing my personal notes regarding your treatment *("psychotherapy notes").* Psychotherapy notes are notes I have made about our conversation during an individual, group, joint or family psychotherapy session, which I have kept separate from the rest of your medical record because they contain tentative hypotheses, personal reminders, etc. 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 already acted 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 Disclosures Requiring Neither Consent nor Authorization

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

- **Child Abuse:** If, in my professional capacity, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or I have reasonable cause to suspect that a child is being abused or maltreated where the parent, guardian, custodian or other person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment or the local child protective services agency.
- **Health Oversight:** If there is an inquiry or complaint about my professional conduct to the New York State Board of Psychology, I must furnish to the New York Commissioner of Education your confidential mental health records relevant to this inquiry.
- **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 you and/or the records thereof; such information is privileged under state law, and I must not release this information without your written authorization, or a court order. However, this privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** I may disclose your confidential information to protect you or others from a serious threat of harm by you. **The New York State SAFE Act (MHL 9.46) requires that, effective March 16, 2013, all mental health professionals report to their local Director of Community Services ("DCS") or their designee when, in their reasonable professional judgment, one of their patients is "likely to engage in conduct that would result in serious harm to self or others". This language means threats of, or attempts at, suicide and/or serious bodily harm to self, or homicidal and/or violent behavior towards others. The local Director of Community Services "DCS" may then disclose the patient's name and other non-clinical identifying information to the NYS Division of Criminal Justice Services (DCJS) to determine if the person has a firearms license. If the patient has a firearms license, the DCJS will report that information to the local firearms licensing official, who must either suspend or revoke the license and who will use this information to make decisions about the granting of a firearms license in the subsequent five (5) years.**

The information regarding the NYS SAFE Act comes from the OMH website. For more information, visit the FAQ page: http://www.omh.ny.gov/omhweb/safe_act/faq.html

- **Worker's Compensation:** If you file a worker's compensation claim, and I am treating you for issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records which contain information regarding your psychological condition and treatment.

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IV. Patient's Rights and Psychologist'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 at 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 to right to inspect and obtain a copy (or both) of your PHI in my mental health and/or billing records for as long as the PHI is maintained in the record. I may deny you access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. Appropriate forms are available for this purpose.
- *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. Forms are available for this purpose.
- *Right to 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. Forms are available for this purpose.
- *Right to a Paper Copy* — You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a copy of this 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 and post the revision in my office. You may, of course, request a copy of the revision.

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 my office and you will be provided with a Complaint Form. Once you fill this out, I will be glad to discuss your concern with you, and do my best to resolve the concern.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The address is available in my office.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

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VI. Addendum (9/9/13):

In January 2013, the U.S. Department of Health and Human Services (HHS) issued the long-awaited final omnibus rule (Final Rule) implementing the Health Information Technology for Economic and Clinical Health (HITECH) Act modifications to the Privacy Rule and other rules under the Health Insurance Portability and Accountability Act (HIPAA). Psychologists must comply with the Final Rule by September 23, 2013.

I will obtain an authorization from you before using or disclosing:

· PHI in a way that is not described in the Notice of Privacy Practices.
· Psychotherapy notes
· When the use and disclosure without your consent or authorization is allowed under other 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 or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

Addendum to Patient's Rights:

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 in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the 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.

Breach Notification Addendum (The Overview is included at the end of this packet)

1. When the Practice becomes aware of or suspects a breach, as defined in Section 1 of the breach notification Overview, the Practice will conduct a Risk Assessment, as outlined in Section 2A of the Overview. The Practice will keep a written record of that Risk Assessment.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the Practice will give notice of the breach as described in Sections 2B and 2C of the breach notification Overview.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

VII. Effective Date

This notice will go into effect on September 9, 2013.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for Julie Davis, PhD.

When the word "my/I" is used below, it will mean your child, relative, or other person, if you have written his or her name here _____.

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

I understand my protected health information is any information that can identify me or my child as an individual, and his/her past, present, or future: a) physical or mental health or condition; b) treatment received, and c) payment information. This agreement does not include consent to release diagnostic assessment results/psychotherapy notes, which have a more stringent level of protection.

I understand that I have the right to review Dr. Julie Davis' Notice of HIPAA Privacy Practices prior to signing this document. The Notice of HIPAA Privacy Practices describes the types of uses and disclosures of my protected health information, as well as my rights and Dr. Julie Davis' duties with respect to my protected health information. I understand that the Notice of HIPAA Privacy Practices is posted in Dr. Julie Davis' therapy office. Dr. Julie Davis reserves the right to change the Notice of HIPAA Privacy Practices.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or Dr. Julie Davis' business operations. Dr. Julie Davis is not required to agree to the restrictions that I may request. However, if Dr. Julie Davis agrees to a restriction that I request, the restriction is binding. I have the right to revoke consent, in writing, at any time, except to the extent that Dr. Julie Davis has taken action in reliance on this consent.

I consent to the use of disclosure of my protected health information by Dr. Julie Davis, Ph.D., for the purpose of diagnosing or providing treatment to my child/adolescent, obtaining payment for my child's healthcare bills, and conducting the business operation of her practice.

Print your name: _____

Child's name (if applicable) _____

Relationship to child (if applicable) _____

Signature: _____

Date: _____