NOTICE OF PRIVACY PRACTICES

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This notice describes how private medical information (PHI) about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I am required by law to maintain the privacy and security of your PHI. And to provide you with this Notice of Privacy Practices. I must honor the terms of this Notice and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and any changes will apply to all information I have about you. The new Notice will be available by request.

Except for the specific purposes described below, I will use and disclose your PHI only with your written authorization. It is your right to revoke such Authorization at any time by giving me written notice.

USES AND DISCLOSURES relating to treatment, payment, or Health Care Operations DO NOT require your written consent. I can use and disclose your PHIfor the following reasons:

1. **For your treatment.** This may include disclosing your information to another health care professional, such as your physician or psychiatrist, though I prefer to have your written authorization for this.
2. **To secure payment for your treatment.** I can use and disclose your information to bill and collect payment for the services provided by me to you, such as to communicate with your insurance company.
3. **For health care operations.** For example, I can use your PHI to contact you when necessary or disclose your PHI to consult with my attorney for advice about legal compliance.

Certain Uses and Disclosures Require Your Authorization

1. **Psychotherapy Notes**. I keep notes related to your treatment. Any use or disclosure of such notes requires your written authorization, unless
    a. It is for my use in treating you.
    b. My use in training or supervising other mental health practitioners.
    c. For my use in defending myself in legal proceedings instituted by you.
    d. For use in investigations regarding my compliance with HIPAA.
    e. Required by law.
    f. Require to help avert a serious threat to the health and safety of your or others.

Certain Uses and Disclosures DO NOT Require Your Authorization

1. When required by state or federal law.
2. For public health activities, such as reporting suspected child, elder or depended adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, such as audits or investigations.
4. For judicial or administrative proceedings.
5. For law enforcement purposes, such as reporting crimes that occur on my premesis.
6. For workers' compensation purposes.

Certain Uses and Disclosures Require You to Have the Opportunity to Object

1. **Disclosures to family, friends or others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care to the payment of your health care, unless you object. The your consent may be obtained retroactively in an emergency situation.

YOUR RIGHTS REGARDING YOUR PHI

1. **To Request Limits on Uses and Disclosures.** You have the right to ask me not to use or disclose certain PHI for treatment, payment or health care operations purposes. I am not required to agree with your request, and I may say "no" if I believe it would affect your health care.
2. **To Request Restrictions for Out-Of-Pocket Expenses Paid in Full.** You may request restrictions on disclosures of your PHI to health plans if the PHI pertains soley to an item or service that you have paid for out-of-pocket in full.
3. **To Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way. For example, home or office phone, or to use a specific email address.
4. **To See and Get Copies of Your PHI.** Other than my notes, you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy or your record, or a summary of it, within 30 days of receiving your written request. I may charge a reasonable fee for doing so, based on the cost of producing your record for you.
5. **To Get a List of the Disclosures I Have Made.** You may request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, health care operations, or those instances in which you have provided me with and authorization.
6. **To Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing, you may request that I correct this. I may say "no" to your request, but I will tell you why in writing withing 60 days of receiving your written request.
7. **To Get a Paper or Electronic Copy of This Notice.**

HOW TO FILE A COMPLAINT ABOUT MY PRIVACY PRACTICES If you think I may have violoated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice:

Anni Schairer
PO Box 511
Winters, CA 95694
530-341-2593

You can also file a complaint with the US Department of Health and Human Services Office for Civil Rights by

1. Sending a letter to 200 Independence Ave, SW, Washington, DC, 20201
2. Calling 1-877-696-6775
3. Visiting www.hhs.gov/ocr/privacy/complaints

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on July 1, 2017.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

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I have been provided a copy of the Notice of Privacy Practices. I have been given the opportunity to ask questions and request clarification, and understand where to get further information.

_____ _____
Client Name Date of Birth

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature, if Appropriate Date

If Client refuses Note of Privacy Practices, or refuses to sign Reciept, Explanation:

_____ _____
Therapist Signature, if Appropriate Date