**Salt Lake Relationship Therapy**

**Health Insurance Portability Accountability Act (HIPAA) and Notice of Privacy Practices**

This document contains important information about HIPAA, a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and healthcare operations. HIPAA requires that I provide you with this Notice of Privacy Practices for using and disclosing PHI for treatment, payment, and healthcare operations. This document explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time.

**Limits of Confidentiality**

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. In some situations, I am permitted or required to disclose information without your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. I cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, consult with an attorney to determine if a court would likely order me to disclose information.
- If a government agency is requesting information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient to defend myself.
- If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier, or an authorized qualified rehabilitation provider.
- I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

  There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:
- If I know or have reason to suspect that a child under 18, an elder, or a vulnerable adult has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any person responsible for the person's welfare, the law requires that I file a report with the Abuse Hotline. Once a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police.

**Client Rights and Therapist Duties: Use and Disclosure of PHI**

***For Treatment:*** I use and disclose your health information internally during your treatment. If I wish to provide information outside of my practice for your treatment, I will have you sign an authorization. Authorization is required for most uses and disclosures of psychotherapy notes.

***For Payment:*** I may use and disclose your health information to obtain payment for services provided to you as delineated in the consent form.

***For Operations:*** I may use and disclose your health information as part of our internal operations. I may also use your information to tell you about services, activities, and programs that I feel might be of interest to you.

***Right to Treatment:*** You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

***Right to Confidentiality:*** You have the right to have your health care information protected. If you pay for a service

or health care item out-of-pocket in full, you can ask us not to share that information with your health insurer. I will agree to such unless a law requires us to share that information.

***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 the restriction you request.

***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and locations.

***Right to Inspect and Copy:*** You have the right to inspect or obtain a copy of PHI. Records must be requested in writing and a release of information must be completed. There is a copying fee of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right to a review, which I will discuss with you.

***Right to Amend:*** If you believe the information in your records is incorrect or missing important information, you can ask to make certain changes/amend your health information. You will need to make this request in writing and express the reasons you want to make these changes. I will decide if it is warranted and respond within 60 days.

***Right to a Copy of This Notice:*** If you received the paperwork electronically, you have a copy in your email. If you have completed this paperwork in the office, a copy will be provided to you per your request.

***Right to an Accounting:*** You generally have the right to receive an accounting of disclosures of PHI regarding you. At your request, I will discuss with you the details of the accounting process.

***Right to Choose Someone to Act for You:*** If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.

***Right to Choose:*** You have the right to decide whether to participate in services with me.

***Right to Terminate:*** You have the right to terminate services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me or contact me by phone to let me know you are terminating services.

***Right to Release Information with Written Consent:*** With your written authorization, your protected information can be released to any person or agency you designate, and we may discuss potential risks and benefits.

***Therapist's Duties:*** I am required by law to maintain the privacy of PHI and to provide you with 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 provide you with a revised notice.

***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, the State of Utah Department of Health, or the Secretary of the Department of Health and Human Services.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM.

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Client Name and Signature Date

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Client Name and Signature Date

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Therapist Name and Signature Date