CREATING HEALTH ALTERNATIVES TOGETHER
CLINICAL FORENSIC ASSESSMENT SERVICES

4475 ROUTE 27 PO. BOX 577 KINGSTON, NJ 08528-0577
OFFICE: (609) 333-1096
FAX: (609) 333-0761

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

THIS NOTICE DESCRIBES HOW CLINICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I may *use* or *disclose* your *confidential health information* (*CHI*), 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 record 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 physician or another psychologist.

- *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your CHI 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 case 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 outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

I may use or disclose CHI 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 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 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 medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of CHI 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 relied 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.

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

Child Abuse: If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

Adult Abuse: If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult (e.g., elderly person, developmentally disabled adult, etc.) has occurred, I must immediately report the abuse to the Washington Department of Social and Health Services. If I have reason to suspect that sexual or physical assault has occurred to a vulnerable adult, I must immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.

Health Oversight: If the NJ Board of Marriage & Family Therapy Examiners subpoenas me as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of state Licensed Professional Counselors or Licensed Clinical Alcohol & Drug Counselors , I must comply with its orders. This could include disclosing your relevant mental health information.

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 to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal 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 advance if this is the case.

Serious Threat to Health or Safety: I may disclose your confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

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 at Alternative Locations – You have the right to request and receive confidential communications of CHI 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 CHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the CHI is maintained in the record. Copying of your records will incur a standard clerical fee and I can withhold your copied records until the fee is paid. I may also deny your access to CHI under other 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.

Right to Amend – You have the right to request an amendment of CHI for as long as the CHI 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 CHI 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.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Counselor's Duties:

I am required by law to maintain the privacy of CHI and to provide you with a notice of my legal duties and privacy practices with respect to CHI.

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 privacy policies and procedures, I will have the revised notice available at my office. Revised notices may also be sent out to you by either email or postal mail unless you have you have made specific arrangements with me for an alternative means to update you (e.g., facsimile).

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please contact me directly at:

Creating Healthy Alternatives Together

Attn: Cliff Koblin MA, LPC, LCADC

PO Box 577

4475 Route 27

Kingston, NJ 08528-0577

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FAX: (609) 333-0761

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Feel welcome to contact me to receive the most up to date mailing information for this address. You have specific rights under the Privacy Rule. I will not take any action against you for exercising your right to file a complaint regarding an alleged violation of your HIPAA rights.

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Notice of Privacy Practices: Patient Acknowledgement

Patient Name: _____Date of Birth: _____

The Notice of Privacy Practices provides in details the uses and disclosures of your protected health information that may be made by this practice, your individual rights and the practice's legal duties with respect to your protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without your written consent or authorization.
- A description of uses and disclosures that will be made only with your written authorization and that you may revoke such authorization.
- Your individual rights with respect to protected health information and a brief description of how you may exercise these rights in relation to:
    - The right to request restriction on certain uses and disclosures of your protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect or obtain a copy of your records and psychotherapy notes.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to a paper copy of the Notice of Privacy Practices from this practice upon request.
    - The right to complain to this practice and to the Secretary of Health and Human Services if you believe your privacy rights have been violated, and that no retaliatory actions will be used against you in the event of such a complaint.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provision effective for all protected health information that it maintains. You can obtain this practice's current Notice of Privacy Practices on request. By signing this, you are stating you have received our Notice of Privacy Practices and understand the policies in place.

Signature: _____ Date: _____