
Pati Anderson, MC, LPC, PLLC

8114 E Cactus Rd #240 • Scottsdale, AZ 85260 • Tel (602) 625-1414 • Fax (480) 427-3554
e-mail: patianderson@cox.net • website: www.patianderson.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review it *CAREFULLY*.

The privacy of your health information is important to me.

MY LEGAL DUTY

I am required by applicable federal and state law, as well as the ethics of the counseling profession, to maintain the privacy of your health information. I am also required to give you this Notice about my practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2006 and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information that I created or received before I made the changes. Before I make significant change in my privacy practices, I will change this Notice and make the new Notice available upon request.

You may request a copy of my Notice at any time. For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed at the top of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

I use and disclose health information about you for *treatment, payment, and healthcare operations*. For example:

TREATMENT: I may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: I may use and disclose your health information to obtain payment for services I provide to you.

HEALTHCARE OPERATIONS: I may use and disclose your health information in connection with my healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to my use of your health information for *treatment, payment or healthcare operations*, you may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: I may disclose your health information to you, as described in the *Patient Rights* section of this NOTICE. I may disclose your health information to a family member, friend or other person to the extent necessary to help with healthcare or with payment for your healthcare, but only if you agree that I may do so.

PERSONS INVOLVED IN CARE: I may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general conditions, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. I will also use my professional judgment and my experience with common practice to make reasonable inferences of your best interests in allowing a person to pick up filled prescriptions, medical supplies, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: I will not use your health information for marketing communications.

REQUIRED BY LAW: I may use or disclose your health information when I am required to do so by law.

ABUSE OR NEGLECT: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: I may use or disclose your health information to provide you with appointment reminders (such as phone or voice messages).

PATIENT RIGHTS:

ACCESS: You have the right to look at or obtain copies of your health information, with limited exceptions. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I cannot practicably do so. I will charge you a fee for expenses such as copy costs and copy/preparation time. You may also request access by sending me a letter to the address at the end of this Notice. If you request copies, I will charge you for my time (at my regular hourly rate of \$140), copy costs, and postage if you want the copies mailed to you. If you request an alternate format or a summary/explanation of your health information, I will charge my regular hourly fee for providing your health information in that format.

[Note: In the event that your records are co-mingled (i.e. if you are a part of a Child Custody Evaluation, Family Court Case, family therapy, mediation, or marriage counseling), I need a signed consent by all parties involved in order to release records. Third party records in your file (i.e. doctors, other professionals, and references) have the right to confidentiality, and will not be released by this office unless ordered to do so by law. Please contact those professionals directly for records.]

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which I or my business associates disclosed your health information for purposes, other *than treatment, payment, healthcare operations* and certain other activities, for the last six years, but not before January 1, 2006. If you request this accounting more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTIONS: You have the right to request that I place additional restrictions on my use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do I will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that I communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that I amend your health information. (Your request must be in writing and it must explain why the information should be amended.) I may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about my privacy practices or have questions or concerns, please contact me.

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

I support your right to privacy of your healthcare information. I will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Please **print** your name here and sign/date below

Patient or legally authorized individual **signature**

Date

Printed name of signed on behalf

Relationship (parent, legal guardian,
personal representative, etc.)