



YOUR STORY

MENTAL HEALTH COUNSELING PLLC

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Notice of Privacy Practices

Policy

A Notice of Privacy Practices, compliant with the HIPAA Omnibus Final Rule, will be given to every patient/client. Copies of prior versions of the Notice will be retained for six (6) years.

PROCEDURE

- 1. The Notice of Privacy Practices is the official description of:**
 - 1.1 How the Covered Entity uses the Protected Health Information (PHI)**
 - 1.2 When the Covered Entity may disclose PHI;**
 - 1.3 The rights of the patient/client with respect to PHI**
 - 1.4 The Covered Entity's legal duties with regard to PHI**
- 2. The Notice of Privacy Practices must contain a statement indicating that the following uses and disclosures will be made only with an individual's written authorization;**
- 3. The Notice of Privacy Practices must contain a statement indicating that the Covered Entity is required to notify the patient/client of any breach of his or her unsecured PHI.**

4. The Notice of Privacy Practices must provide that if a patient/client has paid for services out-of-pocket, the Covered Entity must accommodate the patient's/client's request that the Covered Entity not disclose PHI related solely to those services paid for out-of-pocket if the disclosure is to be made to a health plan for payment or health care operations.
5. The Notice of Privacy Practices is approved by the Privacy Officer. The Privacy Officer is responsible for revising the Notice of Privacy Practices to reflect any changes in practices regarding PHI. The Notice shall be written in plain language.
6. The Notice of Privacy Practices, or a summary of the same, is posted in a prominent location accessible to patients/clients. The complete Notice of Privacy Practices must be made readily available upon request to existing patients. If the Covered Entity has a website, the Notice is also available electronically through the Covered Entity's website.
7. A copy of the Notice of Privacy Practices must be offered to the client/patient at the time of the first service delivery. **EXCEPTION:** If treatment is first rendered in an emergency, the Notice is given as soon as reasonably practicable after resolution of the emergency.
8. The staff member giving the Notice shall ask the client/patient to sign a written acknowledgement of receipt. If the patient/client refuses or is unable to sign, the circumstances will be documented on the acknowledgement form. The acknowledgement form will be retained in the patient's/client's record for six (6) years.
9. The Notice will be promptly revised whenever there is a material change to uses or disclosures of information, the individual's rights, the Covered Entity's legal duties or other privacy practices stated in the Notice. The revised Notice will be made available at each service delivery site for continuing patients to take with them upon request and will be posted on the organization's website, if applicable.

Health Insurance Portability Accountability Act (HIPAA)

Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice 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. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON 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. There are some situations where I am permitted or required to disclose information without either your consent or authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a social worker, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information *without authorization*:

1. ****Judicial and Administrative Proceedings-****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 psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. **Required by Law**-If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. **In Case of Lawsuit**-If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself as applicable throughout the case.
4. **Worker's Compensation**-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.
5. **Business Associates**-I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is 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.

6. Deceased Patients-PHI may be disclosed regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than 50 years is not protected under HIPAA.

7. Medical Emergencies-I may disclose your PHI in a medical emergency situation to a medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency. Family involvement in care-I may provide or disclose information to close family members or emergency contacts involved in your treatment based on your consent or as a necessary to prevent serious harm.

8. Health Oversight-If required-I may disclose PHI to a health oversight agency for activities authorized by law such as audits, investigations, and inspections. Oversight agencies seeking information include government agencies and organizations that provide assistance to the program (such as third party vendors, peer review organizations, and insurance companies.)

9. Law Enforcement-PHI may be disclosed to a law enforcement official as required by law, in compliance with a subpoena (with written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency or in connection with a crime on the premises.

10. Specialized Government Functions-We may review requested from U.S. military command authorities if you have served as a member of the armed forces, authorized officiations for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandator disclosure laws and need to prevent serious harm.

11. Public Health-If required we may disclose PHI for mandatory public health activities to public health authorities authorized by law to collect or receive information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority to a government agency that is collaborating with that public health authority.

12. Public Safety-I may disclose PHI if necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. If the information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

13. Verbal Permission-I may disclose information to family members directly involved in your care and treatment with your verbal permission in emergency situations. A written release of information we be collected in an appropriate time frame following the emergency situation.

14. **With Authorization**-Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

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:

1. **Child Abuse or Neglect**-If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the New York State Abuse Hotline. Once such a report is filed, I may be required to provide additional information.

2. **Adult Abuse or Neglect**-If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the New York State Abuse Hotline. Once such a report is filed, I may be required to provide additional information.

3. **Duty to Warn**-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 or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- **For Treatment** – I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an 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 Therapy Agreement. Examples of payment related activities include making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewed services provided to determine medical necessity or undertaking utilization review activities. If it becomes necessary to use collection process due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purpose of collection.

- **For Health Care Operations** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you. I may also use PHI with third parties that perform various business activities (i.e. billing or typing services) provided we have a written contract with the business that requires it a safeguard for the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Patient's Rights:

- **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 for the purpose of payment or our operations 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 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 PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge 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 of review, which I will discuss with you upon request.
- **Right to Amend** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why 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 completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On 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 not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- **Right to Terminate** – You have the right to terminate therapeutic 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 in session before terminating or at least contact me by phone letting me know you are terminating services.
- **Right to Release Information with Written Consent** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.
- **Breach Notification** – If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a 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 in office during our session.

Notice of Non-Discrimination: Your Story Mental Health Counseling, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Your Story Mental Health Counseling, PLLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

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 New York State Department of Health, or the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave, S.W. Washington D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this notice is July 28, 2023

