**HIPAA NOTICE OF PRIVACY PRACTICES AND CLIENTS’ RIGHTS**

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

Welcome to the practice of Amanda M. Sehr, MS, MA, LPC, MT-BC at Shambhala Wellness. The following notice is an introduction to your rights and responsibilities as a client. This notice describes how mental health and medical information about you may be used and disclosed and how you can get access to this information. This notice also serves to obtain your consent for clinical policies and procedures.

I am required by law to maintain the privacy of your health information and to provide you with notice of my legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about these privacy practices, please contact Amanda Sehr at 940-783-0870.

Effective Date – This notice will go into effect on February 7, 2014.

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations:

I may use or disclose your protected health information (PHI) for the purposes of providing services, collecting payment, or conducting health care operations and for other purposes that are permitted or required by law.

* “PHI” refers to information in your health record that could identify you including demographic information that may identify you and that is related to your past, present or future physical or mental health or condition and related health care services.
* “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 mental health provider. Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI 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.
1. Uses and Disclosures Requiring Authorization:

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are 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 counseling/therapy notes. “Counseling/therapy notes” are notes I have made about our conversation during an individual or group counseling session, which I keep 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 PHI or counseling notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have already acted 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.

1. Uses and Disclosures with Neither Consent nor Authorization:

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

* **Abuse:** If I have reason to believe that a minor child, elderly person, or person with a disability has been or may be, abused, abandoned, or neglected, I must report this concern and observations related to this concern to the appropriate authorities.
* **Adult Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
* **Health Oversight:** If the Texas State Board of Examiners of Licensed Professional Counselors is investigating a complaint that you have filed against me, I may be required to disclose protected health information relevant to that complaint.
* **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and the court subpoenas information about the professional services provided you and/or the records thereof, I may be compelled to provide the information. Although courts have recognized a clinician-client privilege, there may be circumstances in which a court would order me to disclose personal health or treatment information. I will not release your information without attempting to notify you or your legally appointed representative.
* **Professional Harm**: If you disclose sexual contact with another mental health professional with whom you have had a professional relationship, I am required to report this violation to the appropriate licensing board. You have the right to anonymity in the filing of the report.
* **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical harm to yourself or others and I believe you may act on that threat, I have a legal duty to take the appropriate measures, including disclosing relevant confidential mental health information to medical or law enforcement personnel. In both cases, I will only disclose what I feel is the minimal amount of information necessary.
* **National Security**: I may be required to disclose to military authorities the health information of armed forces personnel under certain circumstances. I may be required to disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may be required to disclose mental health information to a correctional institution or law enforcement official having lawful custody of protected mental health information of an inmate or client under certain circumstances.
* **Worker’s Compensation**: If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer’s insurance carrier.
1. Client’s Rights and Counselor’s Duties:

**Client’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. If you pay out-of-pocket in full for services provided, you have the right to request that I not share information about your treatment with your health insurer. I will agree to this request unless a law requires me to share that information.
* *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 when requested in writing.
* *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of your clinical records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. On your request, I will discuss with you the details of the request and denial process. Section 611.008 of the Texas Health and Safety Code allows for up to 15 days for my office to copy, print or otherwise make the requested information available to you.
* *Right to Amend* – You have the right to request an amendment of your health information for as long as the mental health records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, I will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
* *Right to an Accounting* –You generally have the right to receive an accounting of disclosures of mental health information. If your mental health information is disclosed for any reason other than treatment or health operations, you have the right to an accounting for each disclosure of the previous six (6) years, but the request cannot include dates before April 14, 2003. The accounting will include the date, name of person, or entity, description of the information disclosed the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
* *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.
* *Electronic Information* – I do not allow the distribution of client information through electronic means. I will honor requests for client mental health information through phone and postal mail communication only.

**Mental Health Provider 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 will inform you promptly if a breach occurs that may have compromised the privacy or security of your information.
* 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 post a revised copy in the office and provide you with a copy upon request.
1. 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 the Texas State Board of Examiners of Licensed Professional Counselors,

Complaints Management and Investigative Section

P.O. Box 141369

Austin, Texas 78714-1369

or by calling 1.800.942.5540.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. If you choose to file a complaint, I will not retaliate against you.

I have been given the opportunity to receive a copy of this document as well as read it.

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Client Signature Date