

Paula Levinrad, LCSW, CADC I
NOTICE OF PRIVACY PRACTICES

This notice describes how clinical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY

Who will follow this notice

This notice describes the privacy practices followed by Paula Levinrad, as the Practitioner, and by office personnel.

Your health information

This notice applies to the information and records I have about your health, status, and the health services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, diagnoses, treatments, procedures, and similar types of health-related information.

I am required by law to give you this notice. It will tell you about the ways in which I may use and disclose protected health information (PHI) about you and describes your rights and my obligations regarding the use and disclosure of that information.

How I may use and disclose health information about you without your authorization

- **For Treatment.** I may use health information about you to provide you with clinical treatment or services. I may disclose health information about you to other health care providers who are involved in your treatment. For example, information may be shared to create and carry out a plan for your treatment.
- **For Payment.** I may use and disclose health information about you to get payment or to pay for the services you receive. For example, I may need to give your health plan information about a service you received here so your health plan will pay me or reimburse you for the service. I may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for treatment.
- **For Health Care Operations.** I may use and disclose health information about you in order to run the office and make sure that you and my other clients receive quality care. For example, I may use your health information to evaluate the performance of my staff in caring for you or to help us decide what additional services I should offer.
- **Required By Law and for Law Enforcement.** I will disclose health information about you when required to do so by federal, state or local law or in response to a court order.
- **To Avert a Serious Threat to Health or Safety.** I may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others.

For Drug and Alcohol Program Issues: Federal and State law require your written consent each time I release health information. The Consent will specify who is to receive the information, the purpose of the release of information, and a time period after which the Consent will terminate. You may change or cancel a Consent at any time. However, if I am unable to fulfill my requirements related to treatment, payment or health care operations, I may choose to discontinue providing you with health care treatment and services.

In some instances, I may need specific, written authorization from you in order to disclose information such as HIV, substance abuse, and mental health information

Uses and disclosures in special situations

I may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations. Please notify me if you do not wish to be contacted for appointment reminders, or if you would not like to receive information about other treatment or health services. If you advise me **verbally or in writing** that you do not wish to receive such communications, I will not use or disclose your information for these purposes.

- **Appointment Reminders.** I may contact you as a reminder that you have an appointment for treatment at my office.
- **Alternative Treatment or Health Services.** I may tell you about other possible treatment options or health-related products or services that may be of interest to you.
- **Research.** I may use and disclose health information about you for research projects that are subject to a special approval process. I will ask you for your written permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Information Not Personally Identifiable.** I may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, I may be required by military command or other government authorities to release health information about you. I may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** I may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. This is not relevant for clients with drug or alcohol issues.
- **Public Health Risks.** I may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** I may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Family and Friends.** I may disclose health information about you to your family members or friends if you so chose. For example, I may assume you agree to my disclosure of your personal health information to your spouse when you bring your spouse with you into the treatment room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), I may, using my professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only health information relevant to the person's involvement in your care. For example, I may inform the person who accompanied you to the emergency room of your health status.

Other uses and disclosures require your written authorization

I will not use or disclose your health information for any purpose other than those listed above without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may cancel that *Authorization*, **in writing**, at any time. If you cancel your *Authorization*, I will no longer use or disclose information about you for the reasons covered by your

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written *Authorization*, but I cannot take back any uses or disclosures made before your cancelled the *Authorization*.

Your privacy rights

- **Right to Inspect and Copy.** In many cases, you have the right to look at and copy your health information, such as clinical records that I keep.

You must submit a written request to my Privacy Officer/Contact Person, in order to look at and/or copy records. I may charge a fee for the costs of copying, mailing or supplies.

I may deny your request to inspect and/or copy in certain limited circumstances. If you are denied copies of or access to health information that I keep about you, you may ask that my denial be reviewed. If the law gives you a right to have my denial reviewed, I will select a licensed health care professional to review your request and my denial. The person conducting the review will not be the person who denied your request, and I will comply with the outcome of the review.

- **Right to Amend.** If you believe health information I have about you is incorrect or incomplete, you may ask me to correct or update the information. You have the right to request this change as long as the information is kept by this office.

To request an amendment, complete and submit a “Clinical Record Amendment/Correction Form” to my Privacy Officer/Contact Person.

I may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. If your request is denied, I will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. In addition, I may deny your request if you ask me to amend information that:

- I did not create, unless the person or agency that created the information is no longer available to make the change
- Is not part of the health information that I keep
- You would not be permitted to inspect and copy
- Is accurate and complete

- **Right to a List of Disclosures.** You have the right to request a list, or an “accounting” of disclosures. This is a list of the disclosures I made of clinical information about you for purposes other than treatment, payment, health care operations, and the special circumstances involving national security, correctional institutions and law enforcement listed above. The list will not include the disclosures that were made with your written authorization. To obtain this list, you must submit your request **in writing** to my Privacy Officer/Contact Person. It must state a time period, which may not be longer than seven years and may not include dates before April 14, 2003. Your request should indicate how you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, I may charge you for the costs of providing the list. I will notify you of the cost involved and you can decide if you want the list or not.

- **Right to Request Restrictions.** You have the right to request a limitation on the health information I use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information I disclose about you. For example, you could ask that I not use or disclose specific information to a particular party.

I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the “Request for Restriction on Use/Disclosure of Clinical Information” to my Privacy Officer/Contact Person.

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- **Right to Request Confidential Communications.** You have the right to choose how I communicate with you. For example, you can ask that I only contact you at work or by mail.
To request confidential communications, you may complete and submit the “Request for Restriction on Use/Disclosure of Clinical Information” and/or “Request for Confidential Communications” to my Privacy Officer/Contact Person. You do not have to explain the reason for your request. I will accommodate all reasonable requests. Your request should state how you would like to be contacted by me.
- **Continuing education/Consultation and Training Information:** To maintain my license I am required to participate in ongoing continuing education and receive training on subjects relevant to this profession. Professional consultation may be part of this requirement.
- **Right to a Paper Copy of This Notice.** You will be given a copy of this notice. If you have not received a copy of it, you may ask us for one at any time.
To obtain such a copy, contact my Privacy Officer/Contact Person.

Changes to this notice

Changes may be made to this notice. I will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with my office or with the Secretary of the Department of Health and Human Services.

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Acknowledgement of Receipt of Notice of Privacy Practices

I, **[name of client]** _____, acknowledge and agree that I have received a copy of the Notice of Privacy Practices for Paula Levinrad, LCSW.

Client/Parent or Guardian Signature

Date

Client/Parent or Guardian printed name

Relationship to client

Paula Levinrad

Date

FOR PRACTITIONER USE ONLY:

I, **Paula Levinrad** _____ have made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.)

This document is for the client's file. The full copy of the Notice of Privacy Practices is to be provided to the client for their records.