Dr. Laura Burlingame-Lee, Ph.D., L.P.
(970) 776-6043
thepowerofeachother@outlook.com

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information, provide for the electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardized codes and procedures. A piece of this law recently took effect and is known as the HIPAA Privacy Rule. The HIPAA Privacy Rule creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that we give to you a **Notice of Privacy Practices (NPP)** which describes your rights and protections regarding your health care records (PHI).

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 this notice carefully!

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the Ethical Principles of Psychologists and Code of Conduct (referred to hereafter as "APA Ethics Code.") It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

Please initial each item to indicate that you have read and understood each one. We will also verbally discuss these, and you will have the chance to ask and receive information for any questions you may have.

How I may use and disclose health information about you:

_____ For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

_____ For Payment: I may use and disclose your PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for the purposes of collection.

_____ For Healthcare Operations: I may use or disclose, as needed, your PHI in order to support my business activities, including but not limited to, quality assessment activities, case management, employee review activities, licensing and conducting or arranging other business-related activities including submitting for insurance benefits. For example, I may share your PHI with a third party that performs various business activities (e.g., billing services) provided I have a contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will disclosed *only* with your authorization.

_____ Your Authorization: Under the law, I must make disclosures of your PHI to you upon your request. 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 of disclosures permitted by your authorization while it is in effect. Unless you give me a written authorization, I cannot use or disclose your PHI for any reason except those described in this Notice.

_____ To Your Family and Friends: I must disclose your PHI to you. I may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but *only with your authorization*. In the case of family members who are paying for your services, I will obtain a limited release of information allowing me to contact those individuals in order to collect payment.

_____ Verbal Permission: I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission; this verbal permission will be documented in writing as soon as feasible.

_____ Persons Involved in Care: I may use or disclose PHI to notify, or assist in the notification of (including identifying or locating a family member, your personal representative or another person responsible for your care) of your location, your general condition, or death. If you are present, then prior to disclosure of your PHI, 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 PHI that is directly relevant to the person's involvement in your healthcare.

_____ Required by Law: I may use or disclose your health information when I am required to do so by law. These situations include abuse or neglect of a child or vulnerable adult, threats of harm to others whether by you or a person known to you, matters of national security, and direct threats of harm to yourself.

_____ Abuse or Neglect: I may disclose your PHI to appropriate authorities without your consent if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes, as required by law. I may only do so against your will if you are under the age of 18, or are legally considered a vulnerable adult. I may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the 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 for lawful intelligence, counterintelligences, and other national security activities. I may disclose to correctional institution or law enforcement officials having custody of PHI of an inmate or client under certain circumstances.

_____ Without Authorization: Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of circumstances. The types of uses and/or disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the Psychology Licensing Board or the health department)

- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health and/or safety of a person or the public. If 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.

_____ Appointment Reminders: I may use your PHI to provide you with appointment reminders (such as voicemail messages) with your permission.

Your Rights Regarding Your PHI:

_____ You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing:

- Right of Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies (currently $ 0.50/page). If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of you may appeal the decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.
- Right to Amend: If you feel that the PHI I have about you in incorrect or incomplete, you may ask me to amend the information, although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures: You have the right to receive a list of instances in which I disclosed your health information for purposes other than treatment, payment, health operations and certain other activities. If you request this accounting more than once in a 12-month period, I may charge you a reasonable, cost-based fee (currently $80.00/review) for responding to these additional requests.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. I am not required to agree to your request.
- Right to Request Confidential Communications: You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- Right to copy of this notice: You have the right to a copy of this notice.

Contact Information, Questions or Complaints:

_____ If you want more information about my privacy practices, or if you have questions, please contact me at:

Dr. Laura Burlingame-Lee, Ph.D., L.P.
149 W. Oak St. Suite 108
Fort Collins, CO 80524
(970) 776-6043
thepowerofeachother@outlook.com

_____ Generally speaking, the information provided by and to the client (you) during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed

accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: www.dora.colorado.gov/professions/registeredpsychotherapists .

_____ If you are concerned that I may 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 of disclosure of your PHI, or to have me communicate with you by alternative means or at an alternative location, you may complain to me using the contact information listed above.

The effective date of this notice is April 1, 2016. Your signature below indicates that you agree to abide by its terms during our professional relationships.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

_____
Client's printed name

_____ _____
Signature *Date*

If signed by Responsible Party, please state relationship to client and authority to consent:

_____