Third Coast Wellness, P.C.

HIPAA Security Information and Client Rights

Your therapist is required by law to maintain the privacy of your healthcare information, and to provide you with a notice of the legal duties and privacy practices with respect to this information. This notice describes those duties, rights, and practices. Please read carefully. If you have any questions or do not understand any aspect of this document, do not sign this paper. Instead, discuss your concerns or questions with your therapist.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
Your therapist may *use* or *disclose* your ***Protected Health Information*** (***PHI***), for *treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:

II. Other Uses and Disclosures Requiring Authorization
Your therapist may use or disclose PHI for purposes outside of treatment, payment, or health care operations only when/if your appropriate authorization is obtained. In those instances when your therapist is asked for information for purposes outside of treatment, payment, or health care operations, she will request authorization from you before releasing this information. Psychotherapy Notes--the notes your therapist makes during your session—have a greater degree of protection than regular healthcare information.

Should you choose to authorize your therapist to release any confidential information to a third party, you may revoke that authorization (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Your Therapist has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures Not Requiring Authorization

Your therapist is required by law to disclose personal health information under the following circumstances:

- *Child Abuse* – If your therapist has reason to believe that a child has been subjected to abuse or neglect, the therapist must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – Your Therapist may disclose protected health information regarding you if your therapist reasonably believes that you are a victim of abuse, neglect, self-neglect or exploitation.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and your PHI will not be released without a court order.
- *Serious Threat to Health or Safety* – If you communicate to your therapist a specific threat of imminent harm toward yourself or another individual, or if your therapist believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, your therapist may make disclosures that your therapist believes are necessary to protect that individual from harm. If your therapist believes that

you present an imminent, serious risk of physical or mental injury or death to yourself, your therapist may make disclosures he/she considers necessary to protect you from harm.

IV. Patient's Rights and Therapist's Duties

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, Your Therapist is 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. (For example, you may not want a family member to know that you are seeing a therapist. On your request, Your Therapist will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in the practice's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. On your request, your therapist will discuss with you the details of the amendment process.
- *Right to an Accounting* – You have the right to receive an accounting of disclosures of PHI.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of any Authorization to Release Records from Your therapist upon request, even if you have agreed to receive the notice electronically.

Minors: If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they give me authority to make decisions about what information will or will not be disclosed. If they agree, I will provide them only with general information about our work together, unless I feel there is critical information they need to know regarding safety of a minor. In this case, I will notify them of my concern but make every effort to discuss the disclosure with the minor prior to contacting his or her parents. Also, Consent for Treatment must be made by the custodial parent in the event of divorce.

V. Complaints: If you believe your privacy rights have been violated, you may file a complaint with your therapist. You also have the right to submit a complaint to the Secretary of the U.S. Department of Health and Human Services.

I have been informed of laws regarding confidentiality and limits to confidentiality. I have been offered a complete copy of this Notice regarding the HIPAA Security Rule.

Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms during our professional relationship.

Signature of Patient or Legal Guardian:____
Printed Name: ____
Date: _______________________