HIPAA: Your Information. Your Rights. My Responsibilities.

In addition to my standard Informed Consent, which provides for a more detailed description of privacy practices that govern California MFTs, this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record. You can request an electronic or paper copy of your medical record and other health information I have about you. I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.

Ask to correct your medical record. You can ask me to correct health information about you that you think is incorrect or incomplete. If I'm unable to do this, I'll tell you why in writing within 60 days.

Request confidential communications. You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address. I will comply with all reasonable requests.

Ask to limit what I use or share. You can ask me not to use or share certain health information for treatment, payment, or office operations, but I am not required to agree to your request if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask not to share that information for the purpose of payment with your health insurer. I will agree unless legally required to share that information.

Get a list of those with whom I've shared information. You can ask for an accounting of the times I've shared your health information for six years prior to the date you ask, with whom I shared it, and why. I will include all disclosures except for those regarding treatment, payment, and health care operations, and certain other disclosures (such as any you requested). I'll provide one accounting a year at no charge and will charge a reasonable, cost-based fee if you request another one within 12 months.

Get a copy of this privacy notice. You can request a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. I will make sure this person has the authority to act for you before taking any action.

File a complaint if you feel your rights are violated. You can complain if you feel I have violated your rights with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** I will not retaliate against you for filing a complaint.

For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, talk to me. In these cases, you have both the right and choice to tell me to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell me your preference, for example if you are unconscious, I may share your information if I believe it is in your best interest or when needed to address a serious and imminent threat to health or safety.

In these cases I *never* share your information without your specific written permission:

- Most sharing of psychotherapy notes
- Any disclosures that are not described in this document

Under *no* circumstances will your information be sold, or used for marketing or fundraising purposes.

Uses and Disclosures

How do I typically use or share your health information?

- I may use your health information and share it with other professionals who are treating you.
- I may use and share your health information to run my practice, improve your care, and contact you when necessary.
- I may use and share your health information to bill and get payment from health plans or other entities.

Public health and safety issues. I may be permitted or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research or with a coroner, medical examiner, or funeral director when an individual dies; however, **many** conditions must be met before sharing information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Legal Issues. I must share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to ensure that I am complying with federal privacy law. I can share health information about you in response to a court or administrative order, in response to a subpoena, for workers' compensation claims, for law enforcement purposes or with a law enforcement official, and for special government functions such as military, national security, and presidential protective services.

My Responsibilities

- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if any breach that may have compromised the privacy or security of your information occurs.
- I must follow the duties and privacy practices described in this notice and make a copy of it available to you.
- I will not use or share your information other than as described here unless you agree in writing, and you may change your mind at any time. Let me know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice. I may change the terms of this notice, and the changes will apply to all information I have about you. Any new notice will be available upon request, in my office, and on my web site.

Effective Date 8/30/2013
Marcie Scranton, LMFT. 424.652.8520. marciescranton@gmail.com
License: MFC53951

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices,* which provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If you have any questions, or to obtain a copy of a revised notice, please contact me at 424.652.8520.

I acknowledge receipt of the *Notice of Privacy Practices* of Marcie Scranton, LMFT.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patient's acknowledgement of his or her receipt of my Notice of Privacy Practices, including

_____

However, because of

_____

I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____