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**INTEGRITY COUNSELING**  
**NOTICE OF PRIVACY PRACTICES**

**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.**

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The privacy of your health information is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

A new federal law commonly known as HIPAA requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how I may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information I maintain about you and a brief description of how you may exercise these rights. If you have any questions about this Notice please contact me at (360) 356 8756

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I am committed to protecting the confidentiality of your medical information, and am required by law to do so. This Notice describes my legal duties and privacy practices with respect to your medical information. I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed at the end of this Notice.

**I. USES AND DISCLOSURES OF MEDICAL INFORMATION**

**A. Permissible Uses and Disclosures without Your Written Authorization**

In certain situations, which I describe in Section C below, I must obtain your written authorization in order to use and/or disclose your medical information. However, I do not need any type of authorization from you for the following uses and disclosures (the examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law):

- 1. Treatment:** I may use and disclose your medical information in order to provide treatment to you. For example, I may use medical information to diagnose and provide counseling services to you. In addition, I may disclose medical information to other health care providers involved in your treatment.
- 2. Payment:** I may use or disclose your medical information so that services you receive are appropriately billed to, and payment is collected from, your insurer or other payment source. It is my policy to release only demographics, diagnoses, date, and type of service when I have your consent to bill third party payers. If more information is requested by a payer, I will request your written authorization for that disclosure.
- 3. Health care Operations:** I may use and disclose medical information in connection with our health care operations, including quality improvement activities, certification, licensing or credentialing activities. I may contact you as a reminder that you have an appointment. Please notify me if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contact. I may also provide medical information to my consultants and others for operational purposes.
- 4. Your Other Health Care Providers.** I may also disclose medical information to your other health care providers when such medical information is required for them to treat you, receive payment for services rendered to you, or conduct certain health care operations, such as quality assessment and improvement activities.
- 5. Follow-up Contact.** I may also contact you (for example by calling you or sending a letter) to remind you about appointments, or to provide you information about treatment alternatives or other health-related benefits and services we provide and that may be of interest to you.
- 6. Governmental Purposes and Other Uses and Disclosures Required or Permitted by Law:** I may use or disclose your medical information for certain governmental purposes and when I am otherwise required or permitted to do so by law. For example, I may disclose medical information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose medical information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access medical information; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions as otherwise as authorized by law.

**B. Uses and Disclosures When You Have the Opportunity to Object**

- 1. Family and Other Persons Involved in Your Care.** Unless you object, I will use my professional judgment to provide relevant medical information to your family member, friend, or another person that you designate to be involved in your care.

## C. Uses and Disclosures that Require Your Written Authorization

1. **Other Uses and Disclosures.** Uses and disclosures other than those described in Section I.A. and B. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send medical information to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

2. **Use and Disclosure of Your Highly Confidential Information.** In addition, federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your medical information that: (a) is maintained in psychotherapy notes; (b) is about services provided for treatment of mental health disorders; (c) is about alcohol and drug abuse prevention, treatment and referral; (d) is about HIV and other sexually transmitted diseases. In order for me to disclose your Highly Confidential Information for a purpose other than those permitted by law, I must obtain your written authorization.

## II YOUR INDIVIDUAL RIGHTS

A. **Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. **Right to Alternative Communications.** You may request, and I will accommodate, any reasonable written request for you to receive medical information by alternative means of communication or at alternative locations.

C. **Right to Request Restrictions.** You have the right to request a restriction on medical information I use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to me as indicated below. I am not required to agree to any such restriction you may request.

D. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of medical information made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. **Right to Request Amendment.** You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. **Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to me at any time.

G. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact my office. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

## III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on April 14, 2003.

B. Changes to this Notice. I reserve the right to change this notice, and to make the revised or changed notice effective for clinical information I already have about you as well as any information I receive in the future. I will post a summary of the current notice in the office with its effective date clearly shown at the top. You are entitled to a copy of the notice currently in effect.