NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE READ THIS CAREFULLY.

I am required by law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information (Protected Health Information or “PHI”). I will follow the privacy practices that are described in this Notice, I will provide you with the amended Notice for your information and signature.

For more information about my privacy practices, or for additional copies of this Notice, please let me know as questions arise.

I. USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. Permissable uses and disclosures without my authorization. I may use and disclose your PHI without your written authorization for certain purposes described below. The examples provided in each category are not intended to be exhaustive, but instead are to describe type of uses and disclosures of your mental health information that are legally permissible.

1. Treatment: I may use disclosure of your PHI to other clinicians involved in your care in order to provide better integrated treatment to you. For example, I may discuss your diagnosis and treatment plan with your Psychiatrist or Nurse Practitioner. In addition, I may disclose your PHI to other health care providers in order to provide you with appropriate care and treatment.
2. Payment: I may use or disclose your PHI for the purposes of determining coverage, billing, claims management and reimbursement. For example, a bill send to your insurer may include some information about our work together so that the insurer will pay for the treatment. I may inform a health plan about a treatment you are going to receive in order to determine whether the health plan will cover the treatment.
3. Health Care Operations: I may use and disclose your PHI in conjunction with healthcare operations including quality improvement activities, training programs, accreditation, certification, licensing and credentialing activities. For example, I may disclose disguised information about our work for training purposes.
4. Required or permitted by law: I may use or disclose your PHI when I am required or permitted to do so by law. For example, I may disclose your PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or a possible victim of other crimes. In addition, I may disclose your PHI 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 access to state or federal agencies authorized to access your PHI; disclosure 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; disclosures for workers’ compensation claims, and disclosures to military or national security

agencies, coroners, medical examiners and correctional institutions as authorized by law.

B) Permissable Uses and Disclosures that May Be Made Without My Authorization, But for which You have the Opportunity to Object.

1. Family or other persons involved in your care. I may use your PHI to notify or assist or assist in the notification (including identifying or locating) your personal representative, or another person responsible for your care, location, general information or death. If you are present, then I will provide you with an opportunity to object prior to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose your PHI consistent with your prior expressed preference, and your best interest as determined by my professional judgement. I will use my professional judgement and my experience to make reasonable inferences of your best time in allowing another person access to your PHI regarding your treatment with me.
2. Disaster Relief Efforts. I may use or disclose your PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purposes of coordinating notification of your location, general health or death.

C. Uses and Disclosures Requiring Your Written Authorization.

1. Psychotherapy Notes. I will not disclose the records of our work that I keep separate from the medical record for my personal records, known as psychotherapy notes, except as permitted by law.
2. Marketing Communication; Sale of PHI. I must obtain your written permission authorization prior to using or disclosing your PHI for marketing or the sale of your PHI, consistent with the related definitions and exceptions as set forth in HIPPA.
3. Other Uses and Disclosures. Uses and disclosures other than those described in this Notice will only be made with your written permission. For example, you will need to sign an authorization form before I send your PHI to your life insurance company or your attorney. You may revoke any such authorization at any time by providing me with written notification of such revocation.

II. My Individual Rights

A. Right to inspect and copy. You may request access to your medical records and billing information records maintained by me in order to inspect and request copies of the records. All requests for access must be in writing. Under limited circumstances, I may charge a fee for the costs of copying and sending you records requested.

B. Right to Alternative Communications. You may request and I will accommodate any reasonable written request to receive your PHI by alternative means of communication or alternative locations.

C. Right to request restrictions. You have the right to request a restriction on your PHI that I use or disclose for treatment, payment or healthcare operations. You must request any such restriction in writing addressed to Transformational Therapy, PLLC 4705 226th St. SW Mountlake Terrace, WA 98043. I am not required to agreed to any such restriction you may request, except if it is your request to restrict disclosing your PHI for a health plan for the purposes of carrying out payment or healthcare operations, the disclosure is

otherwise not required by law, and the PHI pertains solely to a healthcare item or service which has been paid in full by you or another person or entity on your behalf.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of disclosures of your PHI made by me in the last six years, subject to certain restrictions and limitations.

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

F. Right to Obtain Notices. You have a right to obtain a paper copy of this notice by submitting a request to Transformational Therapy, PLLC, 4705 226th Street SW Mountlake Terrace, WA 98043.

G. Right to Obtain a Notice of Breach. I am required to notify you if I discover a breach of your unsecured PHI, according to the requirements under federal law.

H. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, please contact me at (). You may also file a written complaint with the Director, Office for Civil Rights of the US Department of Health and Human Services. I will not retaliate against you if you file a complaint.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE.

A. Effective Date: This Notice is effective on May 25, 2020.
B. Changes to this Notice: I may change the terms of this notice at any time. If I change the Notice, I may make the new Notice terms effective for all PHI that I maintain including any information I received prior to issuing the new Notice. If I change this Notice, I will post the updated notice on my website. You may also obtain a revised notice by asking me directly.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signature below I, ________________________________ acknowledge that I received a copy of Transformational Therapy, PLLC Notice of Privacy Practices.

____________________ Client Signature	________ Date
____________________ Therapist Signature	________ Date