

**FLORIDA NOTICE OF PRIVACY PRACTICES
(HIPAA – FLORIDA FORM)**

**Notice of Psychotherapist's Policies and Practices to
Protect the Privacy of Your Health Information**

THIS NOTICE DESCRIBES HOW HEALTH, PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose or be required to disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment, and Health Care Operations”
 - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - Payment is when I or you obtain reimbursement from your healthcare provider for my services. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my (office, clinic, practice group, etc.), such as releasing, transferring, or providing access to information about you to other parties.
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II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations only when your appropriate authorization is obtained. An “authorization” is written permission that permits only specific disclosures above and beyond your general consent. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes for any purpose except as noted otherwise herein.

“Psychotherapy notes” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. If we are counseling with you conjointly with another person or persons, we must have written authorization from every participant in those joint or family sessions, unless federal or state law requires us to do otherwise.

You may revoke all such authorizations (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) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insure the right to contest the claim under the policy.

If we begin seeing you with any other family member or relationship partner, and if we agree that we will have one or more session(s) or have communications with you individually without the other member(s) or partner(s) participating, your signature on the informed consent form provided to you before or at the time of our first session is an acknowledgment and agreement that we will use my own discretion and professional judgment in determining what information may be shared with those other counseling participants and will operate as a release that allows us to disclose this information without further authorization or consent.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we know, or have reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that we report such knowledge or suspicion to the Florida Department of Child and Family Services.
- **Adult and Domestic Abuse:** If we know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, we are required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
- **Health Oversight:** If a complaint is filed against us with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform us that you are opposing
- the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, we may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
- **Worker's Compensation:** If you file a worker's compensation claim, we must, upon request of your employer, the insurance carrier, and authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and Psychotherapist's Duties

Patient's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request and may be unable to abide by it in emergency situations. If we cannot agree on the issue of restrictions, you are free to go elsewhere: however, once you agree to particular restrictions, you must abide by them. We cannot agree to limit uses/disclosures that are required by law.
- **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. We must agree to your request as long as it is reasonably easy for us to do so. There may be an additional charge if we comply with your request.
- **Right to Inspect and Copy:** Unless your access is restricted for clear and documented treatment reasons, you have the right to inspect or obtain a copy (or both) of your PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, we will discuss with you the details of the request process. Requests must be made in writing and will be responded to within 30 days. A reasonable charge may be made for copying requested records, but may be waived, depending on your circumstances. We will notify you of any charges before such copies are made.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you

the details of the amendment process.

- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process. We may require requests for accountings to be in writing. Certain disclosures will not be included and disclosures made prior to April 14, 2003, will not be included. Records will be retained for six years unless federal or state law alters the maximum time required for records retention.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you with a written notification, by mail, of those revisions on or before the effective date.

V. Complaints

If you are concerned that we have violated your privacy rights, or if you are dissatisfied with our privacy policies or procedures, you may file a complaint with our practice by mail as described below and you will not be retaliated against for filing a complaint. You also may file a written complaint with the Office for Civil Rights (OCR), US Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, GA, 30303-8909.

VI. Contact

For further privacy information, please contact us at:

Bressler Counseling
2844 Proctor Road
Sarasota FL 34231

VII. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on April 14, 2003. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide our clients with a revised notice by mail on or before the effective date.

Please submit form below. Upon your agreement with our Privacy Policy, you will then be given access to the Patient Forms. Thank you!

_____ **Date** _____
Your Name

Typing your name and clicking the box will act as a legal signature stating:

I have read the above HIPAA statement and **I AGREE** with the terms of Bressler Counseling's Privacy Policy.

