Rebel Rise Counseling

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HIPAA NOTICE OF PRIVACY PRACTICES

HIPAA (Health Insurance Portability and Accountability Act) is a Federal Law enacted in 1996

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE CAREFULLY REVIEW THE FOLLOWING.

This Notice of Privacy Practice describes how your protected health information (PHI) may be used and disclosed to carry out treatment, payment, or health care operations for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Protected health information is information about you, including demographic information, that may identify you and that which relates to your past, present, or future physical or mental health condition and related health care services.

I am required by the State of Washington and Federal law to maintain the privacy of your health information. In my professional and ethical responsibility to assure you that I will hold and protect your PHI in the strictest manner. I only release information with accordance to the Washington State and Federal law Code of Ethics outlined by the American Counseling Association. This notice may be amended at any time, in which, you will receive a copy of new privacy practices.

Treatment: I may use and disclose your PHI to provide, coordinate, or manage your health care and any related services, as necessary. This includes the coordination or management of your health care with a third party.

Payment: Your PHI may be used, as needed, to obtain payment for your health care services. For example, your PHI may be used to verify insurance and coverage, and to process claims and collect fees.

Other Disclosures: I may use or disclose your PHI in the following situations without your authorization. Required by Law: I may use or disclose your PHI to the extent that the law requires. This may include public health issues, abuse and neglect reports, law enforcement, and legal proceedings. Threat to Health or Safety: I may disclose your PHI, as necessary, to minimize an imminent danger to the health or safety to you or any other individual.

Other permitted Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at ANYTIME unless I have taken action in reliance on the use or disclosure indicated in the authorization.

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You have the right to inspect and copy your PHI: You have the right, which may be restricted in certain limited circumstances, to inspect and copy your PHI that I maintain. Under limited circumstances, I may deny access to your records or charge a fee for the costs of copying and sending requested records.

You have the right to request an amendment to your PHI: if you feel that the PHI that I have about you is incorrect or incomplete, you may request to amend the information. However, I am may deny your request under certain circumstances.

You have the right to request a restriction of your PHI: You may ask me not to use or disclose any part or your PHI for the purpose of treatment, payment, or healthcare operations. You must request any such restriction in writing. I am not required to agree to any such restriction you may request.

You have a right to an accounting of disclosures: You have the right to receive an accounting of certain disclosures that I have made, if any, of your PHI.

Your have the right to request to receive confidential communications: You have the right to request confidential communication from me by alternative means or at an alternative location, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to make a complaint: You may complain to me or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. I will not retaliate against you for filing a complaint.

You have the right to obtain a paper copy of this notice from me even if you have agreed to receive the notice electronically: I reserve the right to change the terms of this notice and I will notify you of such changes on the following appointment. I will also make available copies of our new notice if you wish to obtain one. *Please note that by signing this document you are acknowledging that you have received or have been given an opportunity to receive a copy of the HIPAA Notice of Privacy Practices.*

Your signature indicates that you have read this agreement for services and understand its contents.

______________________________	______________________________	_____ /_____ /________
(Client Printed Name)	*(Client Signature)*	*(Today's Date)*
______________________________	______________________________	_____ /_____ /________
Mary Mills, M.A., LMHC, CDP	*(Counselor Signature)*	*(Today's Date)*

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