**Cindi Bockwitz, LPC, CPCS, RPT-S** **www.clbockwitz.com**
M.A., Counseling Psychology
Licensed Professional Counselor
Registered Play Therapist & Supervisor
Certified Professional Counselor Supervisor

# PRIVACY NOTICE

## THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

## PLEASE REVIEW THIS NOTICE CAREFULLY.

I am committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your mental health condition and the treatment you receive from me. This Notice details how your protected health information may be used and disclosed to third parties. This Notice also details your rights regarding your protected health information.

## USE AND DISCLOSURE OF INFORMATION

1. Federal regulations allow me to use or disclose your PHI for purposes of treatment, payment and health care operations without your written authorization:

(a) Treatment – In order to provide you with the care you require, I may provide your PHI to health care professionals who are directly involved in your care for the purpose of coordination or consultation, or to other professional colleagues for the purpose of consultation or supervision. For example, I might consult with your psychiatrist, if you are being treated with medication, in order to assist in your evaluation and treatment.

(b) Payment – In order to obtain reimbursement for services provided to you, I may provide your PHI to appropriate third party payers pursuant to their billing and payment requirements. For example, I may need to tell your insurance plan/employee assistance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations – In order for me to operate in accordance with applicable law and insurance requirements, and in order for me to provide efficient care, it may be necessary for me to compile or disclose your PHI. For example, I may use your PHI if your health plan decides to audit my practice in order to review my performance.

2. I may also use or disclose your PHI without your written authorization in the following instances:

(a) De-identified Information – If the information does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if I obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists me in undertaking some essential function, such as a billing company that assists me in submitting claims for payment to insurance companies or other payers.

(c) Legal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Child Abuse - To the appropriate government authority, as required by law, if I have reasonable cause to believe that a child has been abused.

(e) Health Oversight Activities – To a court or government agency, as authorized by law, if I am the subject of a criminal or civil investigation or disciplinary action arising from your treatment.

(f) Judicial and Administrative Proceeding – Your PHI is privileged under Georgia law and, if requested or subpoenaed by a court or administrative agency, will be released only with your written authorization or pursuant to a court order.

(g) Avert a Threat to Health or Safety - If I believe that such disclosure is necessary to prevent a serious and imminent danger to you or another person, and the disclosure is to an individual who is reasonably able to prevent or lessen the danger.

(h) Workers' Compensation - If you have submitted a Workers' Compensation claim, I may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(i) Required by Law - If the disclosure is otherwise specifically required by law.

3. Uses or disclosures of your PHI, other than those described above, will be made only with your written Authorization. When more than one person has participated in the treatment, I will only use or disclose the PHI of those individuals who have given me written Authorization.

**YOUR RIGHTS**

1. You have the right to:

(a) Revoke any Authorization, in writing, at any time.

(b) Request restrictions on certain use or disclosure of your PHI as provided by law. However, I am not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request. In your written request, you must inform me of what information you want to limit, whether you want to limit my use or disclosure, or both, and to whom you want the limits to apply.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. For example, you may not want a family member to know that you are in treatment with me.

d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request. I may charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, I may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice. The right to inspect and copy your PHI does not include my psychotherapy notes, provided they are separated from the rest of your record. Psychotherapy notes include the contents of our discussions and my analysis, but do not include the dates and times of our meetings, the treatment plan, treatments provided, test results, or your diagnoses, symptoms, functional status, prognosis, and progress to date.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request, which includes a reason that supports your request. I may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by me (unless the individual or entity that created the information is no longer available), if the information is not part of your record, if the information is not part of the information you would be permitted to inspect and copy, or if the information is accurate and complete. If you disagree with my denial, you will have the right, within limits, to submit a written statement identifying what you believe to be incorrect or incomplete, and to have this statement included in your record.

(f) Receive an accounting of disclosures of your PHI as provided by law. To receive an accounting, you must submit a written request. The request must state a time period, which may not be longer than six years, and may not include dates before April 14, 2003. I am not required to provide an accounting of disclosures of your PHI made for the purposes of treatment, payment or health care operations, or for disclosures made with your written authorization.

(g) Receive a paper copy of this Privacy Notice from me upon request.

(h) Complain to me or to the Secretary of HHS if you believe your privacy rights have been violated. All complaints must be in writing.

(i) To obtain more information on – or have your questions answered about – your rights, please discuss your request with me and I will do my best to honor it.

**MY REQUIREMENTS**

1 I:

(a) Am required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing my legal duties and privacy practices with respect to your PHI.

(b) Am required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information than is provided for under federal law.

(c) Am required to abide by the terms of this Privacy Notice.

(d) Reserve the right to change the terms of this Privacy Notice, and to make the new Privacy Notice provisions effective for all of your PHI that I maintain.

(e) Will provide any revised Privacy Notice to you upon request.

(f) Will not retaliate against you for filing a complaint.

**EFFECTIVE DATE**

This Notice is in effect on and after April 14, 2003.

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**PRIVACY NOTICE ACKNOWLEDGEMENT FORM**

By signing below, I acknowledge that I have received and reviewed the accompanying Privacy Notice and that my questions have been answered to my satisfaction.

_____ _____
Name of Client (Printed) Signature of Client

_____ _____
Name of Legal Representative if client Signature of Legal Representative
Is a minor (Attorney, Parent, or Guardian)

_____ Date Signed ____/____/____
Relationship to Client