



ANACORTES COUNSELING

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Licensed Marriage and Family Therapist #LF00001067
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(360) 899-5816

Notice of Privacy Practices

I am required to give you this notice under the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes how psychological/medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

Your “Protected Health Information” (PH) is any information about your past, present, or future physical or mental health conditions or treatment, billing and payment information relating to this treatment, or any other information I have that could identify you. The law protects the privacy of the health information I create and obtain in providing my care and services to you.

Uses and Disclosures for Treatment, Payment, and Health Care Operations:

By signing the attached Acknowledgement Form, you are giving consent for me to use your protected health information in working with you, or to disclose your protected health information to an outside entity for the following purposes:

- Treatment: providing, coordinating, or managing your health care and other services related to your health care. Examples would be when I consult with another health care provider, such as your family physician, or, in the case of a child, consult with a teacher, school nurse, or other educational specialist.
- Payment: obtaining reimbursement for your healthcare; for example, when I disclose your PHI to your health insurer to obtain payment for your healthcare, or to determine your insurance eligibility or coverage.
- Health Care Operations: activities that relate to the performance and operation of my practice. Examples are quality assessment and improvement activities, business-related matters such as audits, and clinical peer review or consultation.

Uses and Disclosures Requiring Authorization:

Aside from my routine treatment, payment, and health care operations, I will not release your protected health information in either oral or written form unless you sign a "Consent for Release/Exchange of Confidential Information" form authorizing specific disclosure.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that we have already released information based on that authorization; or if the authorization was obtained as a condition of insurance coverage.

Uses and Disclosures Which Could Be Made Without Authorization:

I may disclose protected health information without your consent in the following circumstances:

- **Child Abuse:** I am required by law to report suspected abuse or neglect of a child to the proper law enforcement authorities.
- **Adult and Domestic Abuse:** I am required by law to report suspected sexual or physical assault, abuse, abandonment, financial exploitation, or neglect of a vulnerable adult to the appropriate authorities.
- **Threat to Health and Public Safety:** I am required by law to disclose your personal information without authorization if I have reason to believe that disclosure will avoid or minimize imminent danger to your health or safety, or to the health or safety of any other individual or to the public.
- **Health Oversight:** If I am subpoenaed by the Department of Health as part of its investigations, hearing, or proceedings, I must comply and may be required to disclose your relevant PHI.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, I will release information only with the written authorization of you or your legal representative, or a subpoena of which you have been notified, or a court order.
- **Worker's Compensation:** I am required to make all mental health information in my possession that is relevant to your injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

Your Health Information Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on specific uses and /or disclosures of your PHI. However, I am not required to agree to your request.
- **Right to Inspect and Copy:** You have the right to inspect and/or obtain a copy of your PHI in my records. I may deny access under certain circumstances, but in some cases you may have this decision reviewed.

- **Right to Amend:** You have the right to request an amendment of your PHI for as long as the PHI is maintained in the record. I may deny the request if I believe the original information is accurate.
- **Right to Accounting of Disclosures:** You have the right to receive a list of the disclosures that my office has made of your PHI. Some exceptions do apply.
- **Right to Confidential Communications by Alternative Means or at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative location (for example, only calling you at work).

Counselor’s Duties:

- I am required by law to maintain the privacy of your protected health information and to provide you with this Notice of my legal duties and privacy practices with regard to PHI.
- I am required to abide by the terms in this Notice. I have the right to change the privacy practices described in this Notice and then abide by the updated form. You will be given such an update, either in person or through the mail.

To Ask for Help or Complain:

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Dion L. Menser-Andreini, MS, LMFT #LF00001067
 1015 14th Street, Suite F
 Anacortes, WA 98221
 (360) 899-5816

If you believe your privacy rights have been violated, you may discuss your concerns with me. You may also deliver a written complaint to Dion L. Menser-Andreini, MS, LMFT at the office address listed above. You may also file a complaint with the U.S. Secretary of Health and Human Services.

Client: _____ **Date:** _____

Client: _____ **Date:** _____

Therapist: _____ **Date:** _____