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NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT SHOULD BE REVIEWED WITH CARE.

I am required by federal and D.C. law to maintain the privacy of your health information, as well as to give you this notice about privacy practices, legal obligations, and your rights concerning your health information, also known as your “Protected Health Information” (PHI). I am legally bound to follow the privacy practices that are described herein, and these practices may be amended as needs or requirements change.

Uses and Disclosures of Your Protected Health Information (PHI)

The following will explain the ways in which your health information may be used **without your consent** under Federal and D.C. law. In all cases, I will disclose the minimum amount of information necessary to achieve the purpose of said disclosure. This is not intended to be an exhaustive list, but instead is an explanation of cases and scenarios in which disclosure of PHI may be necessary.

1. Treatment: I may use and disclose information related to your treatment to members of your current treatment team (i.e. primary physician or psychiatrist) for the purposes of continuity of care and to coordinate and manage your healthcare and related services. Generally, I will not do so without first discussing this with you and obtaining your consent. In the event of an emergency, however, your consent will not be required to coordinate your treatment.

2. Payment: I may use and disclose information in your protected health record for billing purposes with your insurance plan. Your insurer may require certain information about your treatment prior to authorizing payment. Such information typically includes diagnoses given, dates of treatment sessions attended, and in some cases, treatment plans. I could also provide your PHI to business associates such as billing companies, claims processing companies, and others who process health care claims for my office.

3. Health Care Operations: Examples of health care operations include quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

4. To avoid harm: I may provide PHI to law enforcement personnel or to persons able to prevent or mitigate a serious threat to the health or safety of a person (including you) or the public. For example, if there is a serious imminent threat to your health and safety

(including serious suicide intention) or the health and safety of another individual (including a child or vulnerable adult) or to the public, I will share PHI to prevent or reduce harm. I will only share information with a person or organization who is able to help prevent or reduce the threat.

5. In the event of an emergency, your protected health information may be disclosed in order to allow for your treatment and care.

6. Wherever required by law, your protected health information will be disclosed. Some examples of this may include Health Oversight Activities (if my office were under investigation or assessed for HIPAA compliance), or Judicial and Administrative Proceedings (if you were involved in a court proceeding and your PHI were court-ordered to be released).

6. Worker's Compensation: If you are being treated for Worker's Compensation purposes, I would be required to provide periodic progress reports, treatment records, and bills upon request to you, the D.C. office of Hearings and Adjudication, your employer, or your insurer, or their representative.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization. However, the disclosures listed above are the most common.

Uses and Disclosures Requiring your Written Consent:

Family, Friends, Or Others Involved in Your Healthcare: You may give written consent to have this office provide your PHI to a family member, friend, or other individual designated by you as being involved in your healthcare or for the payment of your healthcare. You may revoke this consent at any time. Retroactive consent may be obtained in emergency situations. In general, any disclosure to individuals not directly involved in your treatment or care will require your written authorization for release of PHI.

Appointment Reminders and Other Communications: This office, at times, may use or disclose your health information to provide you with appointment reminders, appointment changes, or other office communications. These may include voicemail messages, texts, letters, or e-mails. You have the right to amend or revoke your consent regarding these communications.

Note: Your "authorization" to release PHI may be revoked at any time by providing the revocation in writing. This revocation will go into effect when the written notice has been personally received and reviewed.

Your Rights Regarding Your Health Information

A. Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. All requests of this nature must be made in writing. There will be a fee associated with copying records and mailing records if you chose to receive them via mail. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. You may be denied access to Psychotherapy Notes, if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent or serious physical injury. I shall notify you or your representative if I do not grant complete access. Upon your request, I will discuss with you the details of the request and the denial process.

B. Right to Request Confidential Communications: You have the right to request that I communicate with you only in a certain location or through a certain method (i.e. at work only, or through email, etc.) All requests must be received in writing, and reasonable requests will be honored. A reason for the request is not necessary, but I do need to know specifically where and how you wish to be contacted.

C. Right to Request Restrictions: You have the right to request a restriction on the health information that is used or disclosed about you for treatment, payment, or health care operations. Requests for restrictions must be submitted in writing. I am not required to agree with your requested restriction, however, but I will honor your request, unless the restricted health information is needed to provide you with emergency treatment.

D. Right to Accounting of Disclosures: You have the right to request an accounting of the disclosures that have been made of your protected health information. This request must be made in writing and will not include disclosures made for the purposes of treatment, payment, and health care operations.

E. Right to Request an Amendment: You have the right to request amendment of your health information. Your request must be made in writing and should detail the reason for the requested amendment. This request may be denied under certain circumstances. In such cases, the request for amendment will be documented in your record, along with the reason for the denial of the amendment.

F. Right to a Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

G. Questions or Complaints: Any questions or complaints regarding your privacy rights should be addressed to me, Dr. Ellen Connell. You may also contact the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C., 20201. Should you choose to file a complaint, you will not be retaliated against, and your healthcare treatment will not change in any way.

This notice is effective June 1st, 2015. It may be amended at any time, and the revision will be effective for all PHI maintained. In the event of an amendment, a new notice will be posted and you may request a copy of the revised notice.

I acknowledge having received a copy of Dr. Connell' Notice of Privacy Practices.

Client Signature:_____ Date:_____