Notice of Privacy Practices

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

I take the confidence you place in me seriously. I keep records of our interactions, including in-session and out of session interactions. I use this record to provide quality care and to comply with certain legal and ethical requirements. As the material discussed in our sessions is highly personal, the following paragraphs describe the ways in which I protect your health information and circumstances under which I may use and/or disclose it. This notice also defines your rights to your records and my duties and rights as the therapist.

You may call me, free of charge, and I will describe the terms of this notice until you are satisfied with your understanding. You will be asked to provide your signature on the final page of this document acknowledging receipt, understanding and agreement with the policies.

HIPAA

A number of state and federal laws govern the privacy of health information. In compliance with The Health Insurance Portability and Accountability Act (HIPAA), I am required to provide you notice of: (1) how I may use or disclose information from your health record that could identify you (also known as protected health information or PHI); (2) your individual rights with respect to your PHI; and (3) my duties with respect to your PHI.

Uses and Disclosures of PHI

“Use” refers to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. “Disclosure” refers to activities outside my practice such as releasing, transferring, or providing access to information about you to other parties.

I may use or disclose your PHI for “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 this would be when I consult with another health care provider such as your primary care provider or another therapist. I do this in cases where I am seeking additional expertise to assist me in providing services to you. This type of use and disclosure is not limited to the minimum necessary standard.

“Payment” is when I obtain reimbursement for your healthcare. 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. This type of use and disclosure is generally limited to the minimum necessary standard.

“Health Care Operations” are activities that relate to the performance and operation of my practice. Examples include quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. This type of use and disclosure is generally limited to the minimum necessary standard.

In addition to those instances described above, I may use or disclose your PHI without consent or authorization for the following purposes:

As Required by Law: Your PHI may be used and disclosed without your authorization as required by law, including federal, state, or local law.

Child Abuse: As a mandated reporter, I must report any reasonable suspicion that a child is or has been physically, emotionally, or sexually abused or neglected.

Adult and Domestic Abuse: As a mandated reporter, I must report any reasonable suspicion that a vulnerable adult is in need of protective services due to abuse, neglect, exploitation or abandonment.

Health Oversight Activities: I may disclose PHI to the Kansas Behavioral Sciences Regulatory Board if necessary, for a proceeding before the board.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the services I provided you, or the records thereof, such information is privileged under state law and I will not release the information without written authorization except when required by court order. In this case, I will make a reasonable effort to inform you in advance.

Serious Threat to Health or Safety: If you express a serious threat, or intent to kill or seriously injure an identifiable or readily identifiable person or group of people, including self-harm, and I determine that you are likely to carry out the threat, I must take reasonable measure to prevent harm. Reasonable measures may include: directly advising the potential victim(s) of threat or intent, initiating hospitalization, contacting law enforcement, contacting family member(s) or a friend to protect you or the potential victim.

Law Enforcement Purposes: Subject to certain conditions, your PHI may be disclosed to law enforcement officials in the following circumstances: (1) as required by law and

administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement officials's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if I suspect that criminal activity caused the death; (5) when I believe that PHI is evidence of a crime that occurred on my premises; and (6) in a medical emergency not occuring on my premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

Uses and disclosures outside of treatment, payment and health care operations are permissible when you provide "authorization." Authorization is a written permission above and beyond the general consent that permits only specific disclosure of information. When I am asked for information for purposes outside of treatment, payment, and healthcare operations, I will ask you to complete an "Authorization to Use or Disclose of Protected Health Information" form prior to the disclosure. You may revoke all such authorization at any time provided each revocation is in writing. You may not revoke an authorization that I have already relied on to disclose PHI, but you may revoke authorization for future disclosures. You also cannot revoke authorization that was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Please note that "psychotherapy notes" as defined by 45 CFR §164.501 are considered separate from the medical record. Use and disclosure of psychotherapy notes requires your authorization unless the use or disclosure is for:

- my use in treating you
- for use in training or supervising mental health practitioners to help them improve their skills in group, joint, family or individual counseling or therapy
- my use in defending myself in legal proceedings instituted by you
- use by the Secretary of Health and Human Services to investigate my compliance with HIPAA
- complying with the law and the use and disclosure is limited to the requirements of such law
- complying with the law for certain health oversight activities pertaining to the originator of the psychotherapy notes
- use by a coroner who is performing duties authorized by law
- helping to avert a serious threat to health and safety

Your Rights

You have the right to request limits on certain uses and disclosures of your PHI. This includes restrictions on use and disclosure of your PHI for treatment, payment, and healthcare operations. However, I am not required to agree to the restriction you request except in case of a disclosure to a health insurer if you or someone on your behalf has paid for the care in full.

You have the right to request how I send PHI to you. For example, if you do not want a family member to know you are receiving my services, you may request bills or other notices be mailed to a separate mailing address. You may request I leave voicemail messages only on certain phone numbers. I will agree to all reasonable requests.

You have the right to review and/or get a copy of your PHI with limited exceptions. You may see or get an electronic or paper copy of your medical record and certain other information, such as billing information. I will provide you with a copy or summary, if you prefer, within 30 days of receiving your written request. I choose to provide one copy per year for free. I may charge a reasonable cost-based fee for additional copies. I may deny requests for access to PHI under certain circumstances. For example, you may request to see my psychotherapy notes, but I am not required to show them to you. Certain denials can be reviewed and others are "unreviewable."

You have the right to request an amendment of your PHI to correct mistakes or include missing information in your PHI for as long as the record is maintained. I may deny your request, but will provide an explanation of this denial in writing within 60 days of receiving your written request.

You have the right to receive an accounting or list of the disclosures I have made of your PHI for purposes other than treatment, payment, or healthcare operations, or for which you provided me authorization. I will provide this list within 60 days of your written request. I will provide you with this list at no charge, one time per year. I may charge a reasonable cost based fee for additional copies.

You have a right to a paper copy of this notice.

You have the right to complain if you feel your rights have been violated. You can contact Mitchell A Skidmore, LSCSW at 785-205-6588. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S. W., Room 509F HHH Bldg. Washington, D.C. 20201, calling 1-800-368-1019, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html. I will not retaliate against you for exercising your right to file a complaint.

My Duties and Rights

I am required by law to maintain the privacy of PHI, to provide you with a notice of my legal duties and privacy policies with respect to PHI, and to notify affected individuals following a breach of unsecured PHI.

If there is an impermissible use or disclosure of your PHI, I am required to notify you in writing without unreasonable delay and within 60 days.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. Unless I notify you of such changes, I am required to abide by the terms currently in effect.

If I revise my policies, I will post the revisions on my website, provide you with a copy of the revised policies at our next session, or mail you a copy at the address I have on file for you. This notice is effective as of **06/09/2023**.

Acknowledgement of Receiving Notice of Privacy Practices

I ,_____, have read, understood, and agreed to the privacy practices of Mitchell A Skidmore, LSCSW. I have had the opportunity to have the notice explained to me in terms I understand. I understand that I have the right to request a copy of the Notice of Privacy Practices at any time.

_____
(client name)

_____ _____ _____
(signature of client or personal representative) (relationship if rep.) (date)

_____ _____
Mitchell A Skidmore, LSCSW (date)

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