

POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information.

USES AND DISCLOSURE FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:

I may use or disclose your Protected Health Information (PHI) for treatment, payment and for the purpose of health care operations with the consent you have provided by signing my “Agreement for Psychological Services” form, or in certain cases, by requesting that you sign a specific Authorization allowing me to disclose health care information about you.

- “PHI” refers to information in your treatment record that identifies you.
- “Treatment” is when I provide your health care or manage it, for example by seeking a consultation with another health care professional as a way of better serving your needs.
- “Payment” is when I attempt to obtain authorization or reimbursement for services, generally from the information you provide regarding your insurance or managed care coverage.
- “Health Care Operations” are activities that relate to running my practice, which can include an outside assessment of my compliance with regulations, audits, administrative services, case management, and other business-related matters.
- “Use” applies to activities within my office that help to manage the services I provide.
- “Disclosure” applies to activities outside of my office, including providing access or releasing information to other individuals or organizations.

USES AND DISCLOSURES REQUIRING AUTHORIZATION:

By signing an Authorization form, you allow me to use or disclose information about you for purposes of treatment, payment and health care operations. This provides specific permission above and beyond that which you have given by signing my “Agreement for Psychological Services” form. I will request that you sign an Authorization form if I am asked to release information for purposes of your treatment elsewhere, payment or health care operations. I will also need you to sign an Authorization form if you request that I release your Progress Notes. I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice.

These are notes that I have made for my use to assist me in providing the best care possible. These notes contain very sensitive material and are not written with the intention of being released, so they are given a higher degree of protection than PHI.

You may revoke all authorizations at any time by written request. You may not, however, revoke an authorization if I have already taken action on it based on your prior signature. Further, if the authorization was obtained as a condition of acquiring or using insurance benefits, your insurance company has a legal right to receive information to contest a claim.

I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice.

USES & DISCLOSURES NOT NEEDING CONSENT OR AUTHORIZATION:

I may use or disclose PHI without your consent or authorization under the following circumstances;

- If I have reasonable cause to believe that a child has been abused or neglected, I am required to report my suspicion to law enforcement and to the Department of Social and Health Services.
- If I have reasonable cause to believe that an elderly person or other vulnerable adult has been abused, abandoned, exploited or neglected, I am required to report my suspicion to the Department of Social and Health Services. If I have reason to suspect sexual or physical assault, I must additionally inform law enforcement.
- If the Washington Examining Board of Psychology subpoenas me as part of an investigation, I am required to comply and may be asked to disclose your PHI.
- If you are involved in a legal proceeding and a request is made for information regarding the services I have provided. Your PHI is privileged under State law, however I must release your PHI if I am presented with a signed Authorization from you or your representative, if I receive a properly executed subpoena and you have failed to inform me that you are contesting the subpoena, or if I am ordered to release your PHI by a court of law. This privilege does not apply when you are being evaluated by order of the court or for a third party.
- If I have reasonable cause to believe that you are a threat to your own or another person's health or safety, I am required to report this suspicion in order to protect your wellbeing or that of another person.
- If you file a Worker's Compensation claim, I must make available any PHI in my possession that is relevant to your particular injury. Relevance is determined by the Department of Labor and Industries. This department, along with your employer and any personal representative can request your PHI.

- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

PATIENT RIGHTS:

- You have the right to request restrictions on certain uses and disclosures of your PHI, however I am not required to agree to your requested restrictions.
- PHI that you request will normally be provided through your common mailing address and phone numbers. You have the right to provide a written request to receive communication of your PHI at an alternate address or phone.
- You have the right to view or receive a copy of your file including PHI and Progress Notes, however I may deny you access under certain circumstances. You can appeal my denial if you so request.
- You have the right to request an amendment of your PHI, however I may deny your request. Upon your request, I will discuss the process of executing this amendment.
- You have the right to receive an accounting of disclosures made to your PHI for which you have neither provided consent nor authorization. Upon your request, I will discuss the process for obtaining this accounting.
- You have the right to obtain a replacement copy of this notice upon request.
- Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

PSYCHOLOGIST DUTIES:

- I am required by law to maintain the privacy of your PHI and to provide this notice outlining my policy regarding the privacy of your PHI.

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- I may from time to time change my privacy policies and will notify you in writing at your next psychotherapy appointment following that change. Unless I notify you of a change, my policies will remain as written in this document.

COMPLAINTS:

If you believe that I have violated your privacy rights or you disagree with a decision that I make regarding access to your PHI or Progress Notes, you may contact the Examining Board of Psychology at 360-236-4910 or by writing them at P.O. Box 47869, Olympia, WA 98504-7869. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

EFFECTIVE DATE:

This privacy policy is effective as of January 13, 2014

ACKNOWLEDGEMENT: I have read and received a copy of Dr. Heidi Montoya's Notice of Privacy Practices

Signature of Client or Legal Guardian

Date

Name of Client or Legal Guardian (Please print)

Date