CHRISTINA C. HANSON, MS, LMFT
4026 NE 55th Street, Suite B 100
Seattle, WA 98105

www.christinahansontherapy.com

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 this notice carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to me in any form, whether on paper, orally or electronically to be kept confidential. This federal law gives you, the patient, new rights to understand and control how your personal health information is used. As required by law, I have prepared this explanation of how I am required to maintain the privacy of your personal health information and how I may use and disclose that information.

RECORD KEEPING PRACTICES

Standard practice requires me to keep a record of your treatment. This includes a general description of your emotional and psychological functioning, a diagnosis for insurance billing purposes, goals and approach to treatment, symptoms, medications, your progress and homework assignments if given. This record of treatment is your protected health information *or "PHI". I may use or disclose your PHI for treatment, payment, and health care operation purposes.*

I keep all records in locked files for a minimum of seven years, and for children for seven years after they turn 18. After that, at some point I will shred the documents to protect your privacy. Until then, they will be available for your review upon written notice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Without specific written authorization, I am permitted to disclose your health care information for the purpose of treatment, payment for services and health care operations. For example:

Treatment: *I may use or disclose your PHI to coordinate or manage your treatment. For example, I may need to share information with other health care providers involved in your care.*

Payment: *I may disclose your health care information in the process of obtaining reimbursement for services, confirming benefits and coverage, billing or collections activities, and utilization review. For example, I may disclose treatment information to an insurance company when obtaining an authorization or referral.*

Health Care Operations: *I may disclose your PHI during activities that relate to the business aspects of running my practice. Examples of this are quality assessment activities, accounting, case management, legal, audits, insurance and administrative services.*

OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION

- *To report suspected child or elder abuse or neglect*
- *To report when you are a threat to yourself or another's health or safety*
- *To report when you are a victim or potential victim of a crime*

- *To report when you have committed a crime on my premises or against me.*
- *For law enforcement purposes such as when I receive a subpoena, court order, or other legal process.*
- *For health and safety oversight activities, such as the Department of Health.*
- *For disaster relief purposes.*
- *To Military authorities of U.S. and Foreign Military Personnel, or other governmental agency particularly as relates to national or public security.*
- *As required by law.*
- *To persons involved in your care such as a family member, your personal representative or health care worker in cases of emergency, health risks, or death. I may also contact such persons to obtain payment for your healthcare.*
- *To coroners, medical examiners, or funeral directors as authorized by law.*
- *To provide you with appointment or scheduling reminders (such as on voicemail).*

USES AND DISCLOSURES OF HEALTH CARE INFORMATION WITH *YOUR WRITTEN AUTHORIZATION*

I will make all other uses and disclosures of your PHI only when your appropriate signed authorization is obtained. You may revoke this authorization in writing at any time, unless I have already acted upon a prior authorization you permitted.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the right:

- *To receive, read and ask questions about this notice.*
- *Ask me to restrict certain uses and disclosures. While I am not required to grant the request, I will certainly honor any request granted.*
- *Request and receive a paper copy of my most current Notice of Privacy Practices.*
- *To ask me to change your health information, in writing. You may write a statement of disagreement if your request is denied, which I will store in your medical record. I am allowed to prepare a rebuttal, which will also be stored in your record.*
- *When you request, I will give you a list of non-routine disclosures of your health information.*
- *To obtain a copy of your own existing protected health information. This request must be in writing and will involve a small fee.*
- *To ask that your health information be given to you by another means or location.*
- *To cancel prior authorizations to use or disclose health information in writing. Your revocation does not affect information already released or any prior action taken upon it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance.*
- *To file a complaint without retaliation if you believe I have violated your privacy rights. This complaint must be submitted in writing with me and/or with the U.S. Secretary of Health and Human Services.*

THERAPIST'S DUTIES

This notice describes your rights regarding how you may gain access to and control your protected health information and how I may use and disclose it. I am required by law to abide by the terms of this Notice of Privacy Practices *and I reserve the right to change the terms of this notice at any time. Any new* Notice of Privacy Practices *will be effective for all personal health care information that I maintain, whether or not you are still in treatment with me. My revised notice will be posted in my office and you may request a copy.*

I am my own Privacy Officer. If you have any questions about this Notice of Privacy Practices*, please contact me: Christina C. Hanson, MS, LMFT. 3417 Evanston Ave N., Ste. 220. Seattle, WA. 98103. (206) 854-7158.*

CHRISTINA C. HANSON, MS, LMFT
4026 NE 55th Street, Suite B 100
Seattle, WA 98105

www.christinahansontherapy.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. Federal and state law allows providers to use and disclose your protected information to purposes of treatment and care operations. The therapist will not disclose my record to others unless I direct him/her to do so or unless the law authorizes or compels him/her to do so.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this therapist has the right to change his/her *Notice of Privacy Practices* periodically and that I may contact the therapist at any time to obtain a current copy of the *Notice of Privacy Practices.*

By my signature below I acknowledge my receipt of the ***Notice of Privacy Practices***.

_____ _____
Patient signature or legally authorized person Date

_____ _____
Printed Name Relationship (self, parent, Guardian, representative)

This Form will be retained in your record

OFFICE USE ONLY

==========

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Last updated on 06.25.16