

Summit Counseling Center

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPPA (Health Insurance Portability and Accountability Act) and Washington State

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.

Herein, “you/your” refers to the patient/client. “Your counselor” refers to your clinician and Summit Counseling Center.

Effective Date: November 1, 2023

I. HOW PERSONAL HEALTHCARE INFORMATION CAN BE USED

Your Personal Healthcare Information (PHI) contains personal information about you and your health that is protected by state and federal laws aimed at protecting the confidentiality of this information. Your PHI includes, but is not limited to, notes and records created before, during, and after a session, treatment planning, medications, progress, payment information, and any information your counselor receives about you related to your past, present, and future health.

Your PHI can be used for the following:

- **Treatment:** Treatment refers to when your counselor provides, coordinates, or manages your health care with other services related to your health. This may include, for example, consultation with your family physician, psychiatrist, or another health care provider.
- **Payment:** When needed, information needed for payment may be disclosed such as date, length of a session, and billing code.
- **Health Care Operations:** Activities related to the performance and operation of the practice may be disclosed in order to help with things such as quality, audits, record keeping, case management, and care coordination.

Your PHI will also be used for the following unless you specifically object in writing.

- Appointment reminders in writing, by phone, voicemail, and/or email.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

Your PHI may not be used besides for treatment, payment, or health care operations unless an authorization to disclose your information has been signed by you. An authorization gives your counselor written permission for specific disclosures that will be discussed and understood prior to disclosure.

You may revoke any or all authorizations at any time in writing. Authorizations will be revoked for future disclosures as requested in writing. Any disclosures already made

cannot be revoked as your counselor had already relied on the authorization for the disclosure.

III. USES AND DISCLOSURES WITHOUT WRITTEN AUTHORIZATION

Your counselor may use or disclose PHI without your consent or authorization in the following circumstances:

- Information indicating that there is a possibility that a minor is being abused or neglected
- Information that a dependent or elder adult is being abused, neglected, abandoned, or financially exploited
- You are presenting a danger to yourself or others, such as the contemplation of suicide, or the contemplation or commission of a crime or harmful act. Your counselor is required to inform the intended victim and appropriate enforcement agencies.
- You bring charges against your counselor or there is criminal activity at the counseling premises or against your counselor.
- Your counselor receives a legitimate subpoena from a court of law or a health oversight agency
- Emergencies in which you are unable to answer for yourself, such as if you are being transported by an ambulance, unconscious, incoherent, unable to speak for yourself, or in the case of death

IV. RIGHTS AND DUTIES

COUNSELOR'S DUTIES

- Your counselor is required by law to maintain the privacy of PHI and to provide you with a notice of the legal duties and privacy practices regarding PHI.
- Your counselor is required to abide by the terms of the privacy policies and practices described in this document.
- Your counselor reserves the right to change the privacy policies and practices described in this document. If revised, an updated written notice will be provided either by mail, email, or in person. If you are no longer receiving services, you may request a copy of the revised notice and one will be provided.
- Your counselor must notify affected individuals following a breach of unsecured PHI.

PATIENT'S RIGHTS

- The right to request restrictions on certain uses and disclosures of PHI for treatment, payment, or operations. Requests cannot be granted if they will compromise the quality of your care or if required by law.
- The right to receive confidential communications of PHI, as permitted by law. This includes where mail and email are sent as well as phone and voicemails.

- The right to inspect and copy PHI. A reasonable fee may be assessed to cover the costs.
- The right to amend PHI, as permitted by law. Your counselor is not required to amend every request. In these cases, you have the right to file a written statement of disagreement with your counselor along with the disagreement statement and why you believe the information is incorrect or inaccurate. This request will remain in your PHI record with a rebuttal statement from your counselor.
- The right to receive an accounting of disclosures of PHI. This documents any non-routine disclosures made for purposes other than your treatment, payment, and health care operations.
- The right to obtain a paper copy of the notice, upon request.

V. QUESTIONS OR COMPLAINTS

If you have questions about this notice, please contact Deb Culver, MA, LMHC at (360) 299-7994.

If you believe your privacy rights have been violated and wish to file a complaint, you have the right to send a written complaint to the United States and/or Washington Secretary of Health and Human Services at:

Washington State Department of Health
Health Systems Quality Assurance Division
PO Box 47857
Olympia, WA 98504-7857

You may also send a written complaint to the covered entity by contacting the HIPPA Compliance Officer, who is Deb Culver, MA, LMHC. Complaints may be sent to:

Summit Counseling Center
Attn: Deb Culver, MA, LMHC
3014 Commercial Ave, Suite D
Anacortes, WA 98221.

You have specific rights under the Privacy Rule and your counselor will not retaliate against you for filing a complaint.

By signing below, I acknowledge that I have read and understand the information in this document. I have had the opportunity to ask questions and get clarification of anything that is unclear to me. I have been given the opportunity to receive a printed copy of this notice.