Health Insurance Portability Accountability Act (HIPAA)
Client Rights and Therapist Duties

This document describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully as it contains information about federal law, the Health Insurance Portability and Accountability Act (HIPAA) that provides privacy protections and patient rights with regard to use and disclosure of Protected Health Information (PHI).

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. Protected Health Information (PHI) is information about you, including demographic information that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services. The confidentiality of mental health and substance use client recorded is specially protected by State and/or Federal law and regulations. Glendening Therapy Services, LLC is required to comply with these protections. This includes a prohibition, with very few exceptions, on informing anyone outside of treatment that you attend/attended the treatment or disclosing any information that identifies you as a mental health client or a substance use client. If you suspect a violation, you may file a report to the appropriate authorities in accordance with State and Federal regulations. Additionally, Glendening Therapy Services, LLC included in this joint document, will share Protected Health Information with each other, as necessary, to carry out treatment, payment, and healthcare operations. Glendening Therapy Services, LLC, must legally maintain privacy and security of your PHI and follow the duties and privacy practices described in this document. Glendening Therapy Services, LLC will not use or share information other than as described here unless authorized in writing. If you have any questions, it is your right and obligation to ask so I can further discuss prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. The revocation will be binding unless I have taken actions in reliance on it.

How I May Use and Disclose Health Information About You

- ***For Treatment:*** I may use medical and clinical information about you to provide you with treatment or services, coordinating care, or managing your treatment. I may coordinate your PHI to other providers after obtaining written and verbal consent via the informed consent document. An example would be Glendening Therapy Services, LLC requesting a list of your medication from your Primary Care Physician.
- ***For Payment:*** With your authorization, I may use and disclose your PHI about you so that I can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage of insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes. Due to a lack of payment for services, I will only disclose the minimum amount of PHI necessary for the purposes of collection.
- ***For Health Care Options:*** Glendening Therapy Services, LLC may use or disclose your PHI for certain purposes in connection with the operation of my business, including, but not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided that I have a written contract with the business that

requires to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.

- ***Required by Law:*** Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.
- ***Without Authorization:*** Applicable law also permits disclosures about you without your authorization in a limited number of situations, such as with a court-mandated order. These situations are explained below.
- ***Health Oversight:*** I may disclose your PHI to a Health Oversight agency for activities authorized by law, such as for audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as a third-party payers) and peer review organizations performing utilization and quality control. If I disclose your PHI to a health oversight agency, I will have an agreement in place that requires the agency to safeguard the privacy of your information.
- ***Public Health:*** I may disclose your PHI for public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority. In certain circumstances outline in the Privacy Regulations, I may disclose your PHI to a person who is subject to jurisdiction of the Food and Drug Administration with respect to the reporting of certain occurrences involving food, drugs, or other products distributed by such person. In certain limited circumstances, I may also disclose your PHI to a person that may have been exposed to a communicable disease or may otherwise be at risk of spreading or contracting such disease, if such disease is authorized by law. For example, I may disclose your PHI regarding the fact that you have contracted a certain communicable disease to a public health authority authorized by law to collect or receive such information.
- ***Medical Emergencies:*** I may use or disclose your PHI in a medical emergency to medical personnel only and as legally permissible if in treatment at Glendening Therapy Services, LLC.
- ***Coordination of Care:*** I may disclose PHI for the purposes of continuity of care without consent. The purpose of coordination will be limited to admission, treatment, planning, coordinating care, discharge, or governmentally mandated public health reporting.
- ***Mandated Reporting:*** The law protects the privacy of all communication between client and therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required (as described in this document) without either your consent or authorization. If such situations arises, I will limit my disclosure to what is necessary. Reasons I may have to release information without your authorization are:
    - If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Kansas Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
    - If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Kansas Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
    - If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take

protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

- ***Deceased Client:*** I may disclose your PHI regarding deceased clients for the purpose of determine the cause of death, in connection with laws requiring the collection of death or other vital statistics permitting inquiry into the cause of death
- ***Criminal Activity:*** If you are a client, I may disclose your PHI to the law enforcement officials if you have committed a crime within the confines of the building or against personnel or have threatened to do so.
- ***Legal:*** I may disclose your PHI to respond to lawsuits and legal actions. If you are involved in a legal issue where Glendening Therapy Services, LLC is not a party, I may disclose your information with your authorization or court order for situations involving family matters, worker's compensation, civil actions, or other legal issues.
- ***Court Order:*** I may disclose your PHI if the court issues an appropriate order and follows required procedures.
- ***Special Government Functions:*** If you are an active military member or veteran, I may disclose your PHI as required by military command authorities. I may disclose your PHI to authorized federal officials for national security and intelligence reasons and to the Department of State for medical suitability determinations.
- ***With Authorization:*** I must obtain written and verbal authorization from you for all other disclosures of your PHI.

Client Rights and Therapist Duties

Use and Disclosures of Protected Health Information (PHI)

- ***For Treatment*** – I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI. To exercise any of these rights, please submit your request in writing to me at 1623 Poyntz Ave., Manhattan, KS 66502.

- ***Right to Revocation:*** It is your right to revoke any authorizations, at any time by sending a written notification to the me at the address above
- ***Right of Access to Inspect and Copy:*** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause

serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- ***Right to Amend:*** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with myself. I may prepare a rebuttal to your statement and provide you with a copy.
- ***Right to an Accounting Disclosures:*** You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Request Restrictions:*** You have the right to request a restriction or limitation on the use or disclosure of your PHI of your treatment, payment, or health care operations. I are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid out of pocket. In that case, I am required to honor your request for a restriction.
- ***Right to Request Confidential Communication:*** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contract as a condition for accommodating your request.
- ***Breach Notification:*** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- ***Right to a Copy of this Document:*** You have the right to a copy of this document.
- ***Right to Choose Someone to Act for You:*** If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose:*** You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate:*** You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

Therapist's Duties

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Kansas Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client Signature:_____ Date:_____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature:_____ Date:_____

Printed Name:_____ Date:_____

Clinician Signature:_____ Date:_____

Clinician Printed Name & Credentials:_____ Date:_____

*Signatures required: Adult client (18 years or older) and witness; Parent (or guardian) and child plus witness, if child is 12 to 17. Parent (or guardian) and witness if child is under 12 or adjudicated incompetent.