Alanna M. Lipinski, Ph.D.

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NOTICE OF HIPAA PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you get access to this information. Please review it carefully. Your provider, Dr. Alanna Lipinski, PhD, has agreed to abide by the privacy practices described below.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - – *Treatment* is when I provide, coordinate or manage your mental health care and other services related to your child's health care.
  - – *Payment* is when I obtain reimbursement for your mental 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.
  - – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- *Child Abuse* – If I, in the ordinary course of my profession, have reasonable cause to suspect or believe that any child under the age of eighteen years (1) has been abused or neglected, (2) has had non accidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (3) is placed at imminent risk of serious harm, then I must report this suspicion or belief to the appropriate authority
- *Adult and Domestic Abuse* – If I know or in good faith suspect that an elderly individual or an individual, who is disabled or incompetent, has been abused, I may disclose the appropriate information as permitted by law.
- *Health Oversight Activities* – If the NY Board of Examiners of Psychologists is investigating my practice, the board may subpoena records relevant to such investigation.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If I believe in good faith that there is risk of imminent personal injury to you or to other individuals or risk of imminent injury to the property of other individuals, I may disclose the appropriate information as permitted by law.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Also, you may have other rights granted to you by the laws of the State of New York and these may be the same or different than the federal rights I have described above. For further information on New York State Law protecting patient rights, please visit NYS Dept. of Health at http://www.health.ny.gov/professionals/patients/patient_rights/

For further information on HIPAA regulations (Health Insurance Portability and Accountability Act, 1996), or your right to privacy regarding healthcare information, please visit www.hhs.gov/ocr/hipaa (the US Department of Health and Human Services website).

Psychologist'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 notify you in person or in writing.

V. Questions and Complaints

If you disagree with a decision I have made about your records or believe that your privacy rights have been violated, you may send your written complaint to me and/or the Secretary of the US Department of Health and Human Services. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for Alanna Lipinski, Ph.D.

When the word “my/I” is used below, it will mean your child, relative, or other person, if you have written his or her name here: ____

When I interview, assess, examine, diagnose, treat, or refer you or your child, I will be collecting what the law calls Protected Health Information (PHI) about you/your child. I need to use this information to decide which treatment is best and to provide treatment to you/your child. I may also share this information with others who provide treatment for you/your child or need it to arrange payment for your treatment or for other business or government functions.

I understand my PHI is any information that can identify me or my child as an individual, and his/her past, present, or future: a) physical or mental health or condition; b) treatment received, and c) payment information. This agreement does not include consent to release diagnostic assessment results/psychotherapy notes, which have a more stringent level of protection.

I understand that I have the right to review Dr. Lipinski’s Notice of HIPAA Privacy Practices prior to signing this document. The Notice of HIPAA Privacy Practices describes the types of uses and disclosures of my protected health information, as well as my rights and Dr. Alanna Lipinski’s duties with respect to my protected health information. I understand that the Notice of HIPAA Privacy Practices is posted in Dr. Lipinski’s therapy office. Dr. Lipinski reserves the right to change the Notice of HIPAA Privacy Practices.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or Dr. Alanna Lipinski’s business operations. Dr. Alanna Lipinski is not required to agree to the restrictions that I may request. However, if Dr. Alanna Lipinski agrees to a restriction that I request, the restriction is binding. I have the right to revoke consent, in writing, at any time, except to the extent that Dr. Alanna Lipinski has taken action in reliance on this consent.

I consent to the use of disclosure of my protected health information by Dr. Alanna Lipinski., for the purpose of diagnosing or providing treatment, obtaining payment for healthcare bills, and conducting the business operation of her practice.

______________________________________ ______________________

Child’s Name (if applicable) Relationship to Child (if applicable)

____

Printed Name

______________________________________ ______________________

Signature Date