Debra Gibbons M.S. LMFT

321 N. Mall Drive, Bldg. O, #10, St. George, WA 84790

(435) 868-8376 FAX

Encrypted email: [www.schedule.secure](http://www.schedule.secure) or debra.gibbons@gmail.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 it carefully***. I am required by law to maintain the privacy of your **Protected Health Information** **(PHI)** and provide you with notice of my legal duties and privacy practices with respect to your **PHI**. I am required to abide by the terms of this Notice. I am also required by law to notify affected patients following a breach of unsecured protected healthcare information. As part of my practice, I maintain personal information about you and your health. I respect your privacy. I will not disclose your information unless you tell me to do so, or the law authorizes or requires me to do so. My practice reserves the right to revise the terms of this notice and to make new notice provisions effective for all **PHI** that it maintains until the next revision. I will also furnish you with a revised Notice of Privacy Practices upon request. I am my own practices security officer and my contact information is found at the top of this page if you have any questions about how I protect your **PHI**.

State and federal law protects the privacy of the **PHI** created in providing services to you including information such as your name, social security number, address and phone number, your symptoms, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. State and federal law allows me to use and disclose your **PHI** for the purposes of treatment and health care operations only. State law requires your authorization to disclose this information for payment purposes.

**Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations**

**For treatment:**

* Information obtained will be recorded in your health care record and used for the purpose of providing you with health care treatment.
* To coordinate and manage your care, I may also provide information to others providing you care, and to other persons, including family members who are involved in your care.

**For payment:**

* I may disclose your **PHI** to third party payers, with your authorization, to obtain information concerning benefits, eligibility, and coverage, as well as to submit claims for payment and information needed for medical necessity and quality assurance reviews.

**For health care operations:**

* I may disclose your **PHI** to Business Associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist me in my delivery of your health care.

**Other Disclosures and Uses That do Not Require Your Authorization**

**Required by Law:** I may disclose your **PHI** when it is required by law. Examples are public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigation of deaths. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

**Health Oversight.** I may disclose your **PHI** to a health oversight agency such as the agencies that oversee third-party payers and the organizations that audit provision of payments to me.

**Threat to Health or Safety**. I may disclose your **PH**I when necessary to minimize an imminent danger to the health or safety of you or any other individual.

**Appointments.** I may use your **PHI** to contact you for appointments by telephone or text, or e-mail.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient’s Signature or Parent’s Signature if a Minor Date*

**Business Associates.** I may disclose your **PHI** to Business Associates that are contracted by me to perform health care operations or payment activities on my behalf. My Business Associates Agreement contract with them requires them to safeguard the privacy of your **PHI**.

**Compulsory Process.**  I will disclose your **PHI** if a court jurisdiction issues an appropriate order. I will also disclose your **PHI** if (1) you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, identifying the **PHI** sought, and the date by which a protective order must be obtained to avoid my compliance, (2) no qualified judicial or administrative protective order has been obtained, (3) I have received satisfactory assurances that you received notice of an opportunity to have limited or quashed the discovery demand, and (4) such time has elapsed.

**Uses and Disclosures of Protected Health Information With Your Written Authorization**

I will make other disclosures of your **PHI** with your written authorization. You may revoke this authorization in writing at any time, unless I have taken a substantial action in reliance on the authorization such as providing you with services for which I must submit subsequent claim(s) for payment.

# Your Protected Health Information Rights:

* Receive, read, and ask questions about this notice.
* Ask me to restrict certain uses and disclosures in writing. I am not required to agree to your request, but if the request is granted, I will comply with it.
* Request that you be allowed to see and get a copy of your **PHI** in writing.
* Ask me to change your **PHI**. You may give me this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your health care record and included with any release of your records.
* Ask for a list of disclosures of your **PHI**-not included are third-party payers.
* Ask that I communicate with you in a certain way or at a certain location.
* Request a copy of the most current Notice of Privacy Practices for **PHI**.
* Ask me to restrict disclosure to insurance if **PHI** pertains to a service which Practice has been paid for.

## If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer. I will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

**The effective date of this Notice is August 4, 2015.**

**Acknowledgment:** I hereby acknowledge receiving a copy of this notice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient’s Signature or Parent’s Signature if a Minor Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Therapist’s Signature Date*

I wish to request that the only **PHI** kept by Debra Gibbons MS, LMFT, will be my name, my Treatment Plan, our Fee Arrangement/Payment Record, and a signed copy of the Disclosure Form and Notice of Privacy Practices. I wish no Insurance claims to be filed and I will pay on a cash only basis at the time services are rendered.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Client’s Signature Date*