

Notice of Privacy Practices

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Notice of Licensed Mental Health Counselor's Policies to Protect the Privacy of Your Health Information

Note: This is a notice of privacy standards that apply to psychotherapy under the Health Insurance Portability and Accountability Act (HIPAA, 1996). Healthcare providers are required to provide this notice.

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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 with your consent. To help clarify these 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 health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - Payment is when I obtain reimbursement for health care.
 - 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. I will also need to obtain an authorization before releasing any "psychotherapy notes," which are any other notes I make for myself about our conversations, and which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

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 this policy.

III. Uses and Disclosures Requiring Neither Consent nor Authorization

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

- Child Abuse - If I have reasonable cause to believe that a minor child has been abused or neglected, or is placed at risk of serious harm, then I am required to make a report to the appropriate authorities.
- Adult Abuse - If I have reasonable cause to believe that an elderly adult has been abused (including financial exploitation), or that a disabled adult has been abused (including nonconsensual sexual activity), then I am required to make a report to the appropriate authorities.
- Health Oversight Activities - If a licensing or other administrative board 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 written authorization from 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 a risk of imminent serious injury or death to you or to other individuals, I am required to take precautions. These may include notifying emergency services or other authorities, warning potential victims, contacting members of your family who can assist with your safety, or recommending hospitalization.
- **Workers' Compensation** - If you file a workers' compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer, and the Division of Workers' Compensation.

IV. Patient's Rights and Licensed Mental Health Counselor'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 used to make decisions about you 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 the 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 this notice from me upon request, even if you have agreed to receive the notice electronically.

Licensed Mental Health Counselor'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 by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me by email or phone.

If you believe your privacy rights have been violated and wish to file a complaint with me, you may send your written complaints to me at 400 Reservoir Ave, Suite 2C, Providence, RI 02907.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on August 1, 2024.

I reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in person or by mail.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of this HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.