



www.stevebissonlmhc.com

Notice of Privacy Practices

Your health records contain Personal Health Information (PHI). PHI includes identifying information about you related to your past, present, and future physical and mental health conditions and treatment. This Notice of Privacy Practices describes how I may use or share your health information in accordance with applicable law and the LMHC Code of Ethics. It also describes how you may gain access to your record, your rights in controlling use of PHI, and grievance procedures. I am required by law to provide you with a copy of these privacy practices. I reserve the right to revise my practices (in accordance with the law) at any time. You will be notified of any changes in writing.

How I May Use and Disclose Your Health Information

Treatment: With your written consent, I may disclose your personal health information to other health care providers in order to provide, coordinate, or manage your treatment or services. I may communicate with your Primary Care Physician, your insurance company, or any other provider involved in your care.

Payment: I may use and disclose PHI in order to receive payment from a third party (such as your insurance company) for treatment and services provided to you. Examples of payment-related activities include making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Health Care Operations: I may use or disclose information in order to support the operation of my practice. Examples include quality assessment, licensing, and audits.

Uses and Disclosures Not Requiring your Authorization and Consent

I am permitted and/or required to use or disclose your PHI under the following circumstances:

- **Abuse/Neglect:** I am mandated by law to report any suspected abuse/neglect of a child under 18, an elder, or a disabled person.
- **Court Order:** I am required to provide information in legal proceedings if a judge issues a court order.

- **Harm to Self or Others:** I am required to take reasonable steps to protect your safety and that of others in situations of possible suicide, homicide, or violence. This includes my “duty to warn” if you are making specific threats towards an individual(s).
- **Mandatory Government Audits or Investigations:** Examples include Mental Health licensing board or the health department.
- **National Security:** I am required by law to take reasonable steps in the event that you report any attempts to commit a terrorist act or help an individual(s) escape confinement.

Uses and Disclosures Requiring your Authorization and Consent

- You have the right to **inspect and copy your records** related to your health care. I may charge for copying your record.
- You have the right to request **amendment to your PHI**. If there has been a mistake, I will amend the information. I am not required to amend the information if I believe it is correct, but I will document your disagreement in the record.
- You have a right to receive **information through alternative means** in order to protect your privacy. For instance, if you don't want your family to know you are receiving services, you may request that I contact you somewhere other than your residence.
- You have a right to **revoke prior consent/authorization** to communicate with a third party at any time. You may request this in writing and my communications with that party would terminate at the time of the request.
- You have a right to a **copy of this notice**. You may request a copy at any time.
- You have the right to **file a complaint** regarding my privacy practices. If you feel your rights have been violated in any way, you may complain to me directly or send a written complaint to the Secretary of Health and Human Services (200 Independence Avenue S.W. Washington, D.C. 20201.)

I hereby acknowledge that I have received a copy of and been given the opportunity to ask questions regarding the privacy practices of Steve Bisson, LMHC. I further acknowledge that I understand and am in agreement with these privacy practices.

Signature of Client/Legal Guardian

Date