

Great Northern Therapy Associates/Angela MacDonald-Hertz LLC

Post Falls, ID 83854

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EFFECTIVE DATE OF THIS NOTICE This notice is effective as of 01/03/2023

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 READ IT CAREFULLY.

I. MY PLEDGE REGARDING MEDICAL INFORMATION: I understand that medical information about you and your medical care is personal. I am committed to protecting your medical information. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose your medical information. I also describe your rights regarding the medical information I maintain about you and describe certain obligations I have regarding the use and disclosure of your medical information. I am required by law to:

- Make sure protected health information (“PHI”) that identifies you is kept private.
- Provide you with this notice of my legal duties and privacy practices with respect to health information.
- Please follow the terms of the notice that is currently in effect.
- I may change the terms of this Notice, and those changes will apply to all information I have about you. The new Notice will be available upon request at my office through electronic communication.

II. HOW I MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION: The following categories describe different ways I use and disclose your medical information. For each category of uses or disclosures, I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment, Payment, or Health Care Operations: Federal privacy rules (regulations) permit health care providers who have a direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment, or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider, including the Department of Labor and Industry. This may also be done without your written authorization. For example, if a physician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose

your otherwise confidential personal health information to assist the physician in diagnosing and treating your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard, as therapists and other health care providers need access to complete records and/or information to provide quality care. The word “treatment” includes, but is not limited to, coordination and management of health care providers with a third party, consultations between health care providers, and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose medical information in response to a court or administrative order.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I maintain “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health professionals to assist them in improving their skills in group, joint, family, or individual therapy or counseling. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities relating to the creator of the psychotherapy notes. g. Required by a medical examiner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of Protected Health Information. As a psychotherapist, I will not sell your protected health information in the ordinary course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in law, I may use and disclose your PHI without your authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to the health or safety of any person.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes that occur on my premises.
6. To forensic doctors or coroners, when such persons are performing functions authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or helping to ensure the safety of those working or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an authorization from you, I may provide your PHI to comply with workers' compensation laws.
10. Appointment Reminders and Health-Related Benefits or Services. I may use and disclose your PHI to contact you as a reminder that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives or other health care services or benefits I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE THAT YOU HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person you identify who is involved in your care or the payment for your care, unless you object in whole or in part. The opportunity to give consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PHI:

1. The right to request limits on uses and disclosures of your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request and may say "no" if I believe it would affect your health care.
2. The right to request restrictions on out-of-pocket expenses paid in full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI relates solely to a health care item or service for which you have paid out-of-pocket in full.
3. The right to choose how I send you PHI. You have the right to ask me to contact you in a specific way (for example, home or office phone) or send mail to a different address, and I will accommodate all reasonable requests.
4. The right to see and get copies of your PHI. In addition to "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and Great Northern Therapy Associates may charge a reasonable, cost-based fee for doing so.
5. The right to obtain a list of disclosures I have made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment or health care operations, or for which you provided me with an authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your

request. The list I will give you will include disclosures made in the past six years unless you request a shorter period. I will provide you with the list at no charge, but if you make more than one request in the same year, Great Northern Therapy Associates may charge a reasonable, cost-based fee for doing so for each additional request.

6. The right to correct or update your PHI. If you believe there is an error in your PHI or that important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may deny your request, but I will tell you why in writing within 60 days of receiving your request.
7. The right to receive a paper or electronic copy of this Notice. You have the right to receive a paper copy of this Notice and to receive a copy of this Notice by email. Even if you have agreed to receive this Notice by email, you also have the right to request a paper copy of this Notice.

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 acknowledge that you have received a copy of the HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, YOU AGREE THAT YOU HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED HEREIN.

Print: _____ Date: _____

Signature: _____