

Soundview Health Associates, PLLC
621 Pacific Avenue, Suite 310
Tacoma, WA 98402
(253) 444-3557

Notice of Privacy Practices

To our clients: This notice describes how health information about you, as a client of this practice, may be used and disclosed, and how you may access your health information. This is required by the Health Insurance Portability and Accountability Act of 1996, or "HIPAA."

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your file, and we do so willingly. HIPAA is our way of alerting you, though, to a few very special circumstances under which your information could actually be released. Although these laws are complicated and some may seem unrelated to the work we do together, we wish to provide you this information, below:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your Protected Health Information (PHI) without your prior authorization:

1. To public health authorities and health oversight agencies authorized by state and federal law to collect health information (for example, if there were a smallpox outbreak).
2. As part of a lawsuit or similar proceedings, in response to a court order or an administrative order.
3. If required to do so by a law enforcement official, in compliance with a court order or a subpoena.
4. When necessary, to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public (for example, if you were threatening to kill someone). We would only make disclosures to a person or organization able to help prevent this threat.
5. If you are an active member or veteran of U.S. or foreign military forces, your record could be requested by the appropriate authorities.
6. To federal officials for intelligence and national security activities, as authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or are under the custody of a law enforcement official.
8. For Workers Compensation and similar programs, if you file for these benefits.

Even if the law compelled us to release information under such special circumstances, we would communicate with you – in advance whenever possible – to apprise you of this.

YOUR RIGHTS CONCERNING PROTECTED HEALTH INFORMATION

1. You may request that our practice communicate with you about your health information in a particular manner or only at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You may request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. (For example, you may have insurance but choose not to submit your therapy costs for reimbursement.) Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or payment for your care (for example, that we speak with one of the doctors who treated you but not to another.) We are not required to agree to such a request, but if we do so, will be bound by that agreement except when required by law, in emergencies, or when that information is necessary to treat you.
3. You have the right to inspect and copy the health information used to make decisions about you, including diagnosis and billing records, but excluding psychotherapy notes. You must submit your request in writing to your psychologist.
4. You may ask to amend the health information maintained by your psychologist if you believe it is incorrect or incomplete. Your request for an amendment must be made in writing to your psychologist. You would provide him or her a written rationale to support your request for amendment.
5. You have a right to copy this Notice of Privacy Practices; you may request it at any time.
6. You have the right to file a complaint. If you believe your legal privacy has been violated by your psychologist, you may file a complaint about him or her with the Washington State Department of Health. To do so, submit your concerns in writing to: Examining Board of Psychology, P.O. Box 47869, Olympia, WA, 98504 or phone them at (360) 236-4910. You would not be penalized in your therapy relationship for filing a complaint.
7. You have the right to provide us authorization for other uses and disclosures of your health information not identified by this privacy notice or permitted by applicable law (for example, if you would like your psychologist to be able to speak with a family member.) At your request, we will obtain your written authorization with a *Consent for Release of Information*. Just ask your psychologist if you may complete this form.

If you have any questions regarding our health information privacy policies, please ask your psychologist to clarify. We will be happy to do so.

I hereby acknowledge that I have been presented with the Notice of Privacy Practices by Soundview Health Associates, PLLC, and that I have read and understood this document.

Signature

Date Signed

Printed Name

Signature of Parent or Guardian (if Minor)

Date Signed

Printed Name of Parent or Guardian