

# Renewed Mind Counseling Service LLC - Notice of Privacy Practices/HIPPA

Renewed Mind Counseling Service LLC

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## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

**Your Protected Health Information.** We refer to your mental, behavioral, medical, and other health care information as "protected health information" or "health information". It may include information about your past, present or future physical or mental health or condition. Health information includes the past, present, or future payment for care. Health information can be transmitted or maintained in any form or medium.

**Confidentiality of Your health information.** Your health information is confidential. We are required to maintain the confidentiality of your health information by Federal and Florida laws. Except as described in this Notice, it is our practice to obtain your authorization before we disclose your health information to

another person or party.

## LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. We may disclose your health information to government agency/public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or another lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

2. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.

2. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

3. If a client files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.

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There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment:

1. If I know or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.

2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.

3. If I believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the client.

## **CLIENT RIGHTS AND THERAPIST DUTIES**

**Uses and Disclosures of Protected Health Information:** The HIPAA Privacy Regulations permit us to use and disclose your health information for the following purposes in order to provide your treatment:

- **For Treatment.** We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for the release of information. This use includes the provision, coordination, or management of health care and related services by one or more health care providers. This includes consultation with other health care providers or the referral of a client from one provider to another. Furthermore, authorization is required for most uses and disclosures of psychotherapy notes.

- **For Payment.** We will use and disclose your health information to obtain payment for services. This includes any activities to obtain reimbursement for health care services that can include: determination for eligibility or coverage, billing, claims management, collection activities, or utilization review.
- **For Health Care Operations.** We may use and disclose your health information within the company in order to carry out our health care operations. For example, your health information is used for: business management and general administrative duties; quality assessment and improvement activities; medical, legal, and accounting reviews; business planning and development; licensing and training. This information will then be used in an effort to improve the quality and effectiveness of the services we provide.
- **Right to Confidentiality.** You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- **Right to Request Restrictions.** You have the right to request a limitation or a restriction on our use or disclosure of your health information for treatment, payment, or healthcare operations. You may also request that we limit the health information we disclose to family members, friends, or a personal representative who may be involved in your care. However, I am not required to agree to a restriction you request. If we agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless it is needed to provide emergency treatment.
- **Right to Receive Confidential Communication by Alternative Means at Alternative Locations** - You have the right to request and receive confidential communications of PHI by alternative means way or at an alternative location. For example, you can ask that we only contact you at your home or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for specific information. Please make this request in writing specifying how or where you wish to be contacted.
- **Right to Inspect and Copy.** You have the right to inspect or obtain a copy (or both) of PHI. However, you may not inspect or copy the following records: psychotherapy notes; or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. You may be denied access to your health information if it was obtained from a person under a promise of confidentiality, or disclosure is likely to endanger the life and physical safety of you or another person. A decision to deny access may be reviewed. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other related costs. Please make your request in writing and well in advance and allow 2 weeks to receive the copies.
- **Right to Amend.** If you believe the health information that we have collected about you is incorrect, you have certain rights. If you are receiving mental health services, you have the right to submit a written statement qualifying or rebutting information in our records that you believe is erroneous or misleading. This statement will accompany any disclosure of your records. You also have the right under the HIPAA Privacy Regulations to request an amendment of the health information maintained in our records. We may deny your request for an amendment if it is not in writing or does not include a

reason to support the request. We may deny your request if you ask us to amend health information that: was not created by us (unless the person or entity that created the information is no longer available to make the amendment); the information is not part of the record kept by us; the health information is not subject to inspection or copying, or the record is accurate and complete. If we deny your request to do so, we will tell you why within 60 days.

- **Right to a Paper Copy of this Notice.** You have the right to receive a paper copy of this Notice upon request
- **Right to Receive an Accounting of Disclosures.** You have the right to request an "accounting of disclosures". This is a list of the disclosures we have made of health information about you. We are not required to account for disclosures related to: treatment, payment, or our health care operations; authorizations signed by you; or disclosures to you, to family members or your personal representative involved in your care, or for notification purposes.
- **Right to choose someone to act for you** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action
- **Appointments and Services.** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you.
- **Right to Choose** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- **Right to Terminate** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- **Right to Release Information with Written Consent** – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

## COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

### 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 HIPAA Notice of Privacy Practices.

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