Wendy Littner Thomson, M.Ed., LPC, RYT
Counseling Services
408 N. New St.
Bethlehem, PA 18018
610-730-1992
wlt206lehigh@gmail.com

# HIPPA Notice of Privacy Practices

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. Effective April 14, 2003.

Wendy Littner Thomson, M.Ed., LPC, CGCS, RYT will only release information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes the policies related to the use and disclosure of your healthcare information.

**Use and disclosure of protected health information for the purpose of providing services:** Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes.

**I.HOW I MAY USE OR DISCLOSE INFORMATION ABOUT YOU**

**Treatment:** As a rule, I will not disclose any information about you or the fact that you are my client(s) without your written consent. On the occasion that I am coordinating your care with other healthcare providers I may request your permission to share information in order to increase the effectiveness of treatment. The content of this information will be reviewed with you in advance.

**Payment:** I may use and disclose information about you so that services you receive from me may be billed and payment collected from you or another third party.

**For Health Care Operations:** I may use or disclose information about you (without identifying details such as name, address, workplace, or other information that would
allow another person to know your identity) for the purposes of professional consultation designed to enhance the effectiveness of services I am providing for you.

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**II.OTHER USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT**

**Emergencies: I**f you are involved in a life-threatening emergency and I cannot ask your permission I will share information I believe will be helpful to you.

**Child Abuse Reporting:** I am required to report suspected child abuse immediately to the Pennsylvania Department of Public Welfare.

**Adult and Domestic Abuse:** If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

**Serious Threat to Health or Safety of Self/Others:** If you express a serious threat, or intent to kill or seriously injure oneself, an identified, or readily identified person or group of people, and I determine that you are likely to carry out the threat, I must take responsible measures to prevent harm.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent or a court order.

**III.Client Rights**

**Right to Request Where I Contact You:** Please inform me if there is a phone number and/or address that you prefer to use.

**Right to Release Information:** Your written authorization is required in order for me to release your information to others. You have the right to revoke this authorization at any time by written request (except to the extent action has been taken in reliance thereon).

**Right to Inspect Records:** You have the right to request amendments to your record. Please submit your request in writing and specify which information you wish to inspect or copy. A fee may be charged for copying, mailing, and supplies. I will typically act on your request within 30 days.

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**Right to Add Information or Amend Your Records:** You have the right to request amendments to your record. Please submit your request in writing and specifically state your reason for the amendment and include your name and contact information. I will typically act on your request within 30 days. I may deny your request to amend your record if I determine that the information you wish to amend was not created by me, not part of the record I maintain, is accurate and complete.

**Right to Accounting Disclosures:** You may request an accounting of the disclosures of your record for a maximum of 6 years and that have been made after April 14, 2003. The list of disclosures does not include disclosures for treatment, payment and healthcare operations, made with your authorization, to you, or for national security or intelligence purposes. Please submit your request in writing and include the time period for which you would like an accounting, your name, and contact information. I will typically act on your request within 30 days.

**Right to Request Restrictions on Uses and Disclosures of Your Records:** You have the right to request restrictions on the uses and disclosures of your record to carry out treatment, payment, or healthcare operations. I am not obligated to agree to your request, but will inform you in advance if I cannot comply. Please submit your request

in writing and include what information you would like to restrict, whether you wish to limit the use or disclosure, or both, and to whom you would like the limits to apply. Also include your name and contact information. I will typically act on your request within 30 days.

**Right to Complain:** If you believe your privacy rights have been violated please contact me first. If you are not satisfied with my response, you may file a complaint with the U.S. Department of Health and Human Services. Send a written complaint to: Region III, Office for Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, Pa. 19106-9111. You will not be penalized in any way for filing a complaint.

**Right to Receive Changes in Policy:** You may request a paper copy of these policies at any time and inquire about changes that have occurred.

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## HIPPA NOTICE

By signing below, I signify that I have read and received the HIPAA Regulations, and I understand my rights to medical and mental health confidentiality and privacy.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Parent Signature (If client is under 14 years of age) Date

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_____ _____

Parent Signature (If client is under 14 years of age) Date

_____ _____

Therapist Signature Date