

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 REVIEW IT CAREFULLY.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information (“Protected Health Information” or “PHI”). I must follow the privacy practices that are described in the Notice and notify you of any breach of unsecured PHI related to you. If I amend this Notice, I will provide you with the amended Notice for your information and signature.

For more information about my privacy practice, or for additional copies of this Notice, please let me know your questions as soon as they arise.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

a. **Permissible uses and Disclosures without Your Written Authorization:** I may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures of your mental health information that are legally permissible.

1. **Treatment:** I may use and disclose PHI to other clinicians involved in your care in order to provide integrated treatment to you. For example, I may discuss your diagnosis and treatment plan with your psychiatrist or nurse practitioner. In addition, I may disclose your PHI to other health care providers in order to provide you with appropriate care and continued treatment.
2. **Payment:** I may use or disclose your PHI for the purposes of determining coverage, billing, claims management, and reimbursement. For example, a bill sent to your health insurer may include some information about our work together so that the insurer will pay for the treatment. I may also inform your health plan about a treatment you are going to receive in order to determine whether the plan will cover the treatment.
3. **Health Care Operations:** I may use and disclose your PHI for the health care operations of my professional practice in support of the functions of treatment and payment. Such disclosures would be to Business

Associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist me in my delivery of your health care.

4. **Required by Law.** I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigation of deaths. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.
5. **Health Oversight.** I may disclose your PHI to a health oversight agency for activities authorized by law, such as my professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to me, such as third-party payers.
6. **Threat to Health or Safety.** I may disclose your PHI when necessary to minimize an imminent danger to the health or safety of you or any other individual.
7. **Compulsory Process.** I will disclose your PHI if a court issues an appropriate order. I will also disclose your PHI if (1) you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, identifying the PHI sought, and the date by which a protective order must be obtained to avoid my compliance, (2) no qualified judicial or administrative protective order has been obtained, (3) I have received satisfactory assurances that you received notice of your right to seek a protective order, and (4) the time for your doing so has elapsed.

b. Uses and Disclosures Requiring Your Opportunity to Agree or Object.

1. **Prior Providers.** I may disclose your PHI to your prior health care providers, unless I have given you the opportunity to agree or object, and you have objected in writing.
2. **Close Personal Relationships.** In accordance with good professional practice, I may disclose your PHI to person(s) who are close to you that are involved with your care, unless I have given you the opportunity to agree or object, and you have objected. When you are not present, or in situations of your incapacity or in an emergency, and where disclosure, in my clinical judgment would be in your best interests, I will disclose your PHI as minimally necessary.
3. **Disaster Relief Efforts.** I may use or disclose your PHI to a public or private entity authorized by law or its charter to assist in disaster relief

efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

- c. **Uses and Disclosures Requiring Your Written Authorization:** I will make other uses and disclosures of your PHI only with your written authorization. Unless I have taken a substantial action in reliance on the authorization such as providing you with health care services for which I must submit subsequent claim(s) for payment, you may revoke an authorization in writing at any time. (**Note about Psychotherapy Notes:** I will not disclose the records of our work that I keep separate from the medical record for my personal use, known as psychotherapy notes, except as required by law.)
- d. **Certain Uses and Disclosures of PHI I do not make.** I do not engage in academic or commercial research involving patient PHI. I do not engage in marketing activities using patient PHI. I do not engage in the sale of patient PHI. I do no fundraising using patient PHI. I do not maintain directory information for public disclosure. I do not receive compensation for recommending any health care product or service.

2. YOUR INDIVIDUAL RIGHTS

- a. **Right to Inspect and Copy:** You may request access to your clinical records and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. I may charge a reasonable, cost-based fee for the copying process. Under limited circumstances I may deny access to your records.
- b. **Right to Amend:** If you feel the PHI I have about you is incorrect or incomplete, you may ask me in writing to amend the information although I am not required to agree to the amendment. You may write a statement of disagreement if your request is denied. The statement will be maintained as part of your PHI and will be included with any disclosure.
- c. **Right to Accounting of Disclosures:** Upon written request you may obtain an accounting of disclosures of your PHI made by me in the last six years, subject to certain restrictions and limitations.
- d. **Right to Request Restrictions.** You have the right to request in writing a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am generally not required to agree to such a request. If I have been paid in full for all of the services covered by such a request, then I will honor a request to restrict disclosure to your insurance.
- e. **Right to Confidential Communications:** You may request and I will accommodate any reasonable written request for you to receive PHI by

- alternative means of communication or at alternative locations. I will not ask why you are making the request.
- f. **Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice upon request.
 - g. **Questions and Complaints:** Since I am in private practice, I am my own Privacy/Security Officer. If you desire further information about your privacy rights or are concerned that I have violated your privacy rights please contact me at 206-723-3402. You may also file a written complaint with the Secretary of Health and Human Services if you believe I have violated your privacy rights. ***I will not retaliate against you if you file a complaint.***

3. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

- a. **Effective Date:** This Notice is effective on March 31, 2014.
- b. **Changes in this Notice:** I may change the terms of this Notice at any time. If I change this Notice I will make the new Notice terms effective for all PHI that I maintain at that time. I will provide you a new copy of this Notice at our next session and post the revised Notice on my website at kellyross.com.

Kelly L. Ross, P.L.L.C.
1818 Westlake Avenue North - Suite 118
Seattle, WA 98109

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

By my signature below I, _____, acknowledge that I reviewed and received a copy of the following documents:

_____ Notice of Privacy Practices for Kelly L. Ross, P.L.L.C.

_____ Health Care Provider Disclosure Form

Signature of Client (or personal representative)

Date

For Official Use Only

I attempted to obtain written acknowledgement of receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

This form will be retained in your medical record.