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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.

1. **Introduction**

This notice tells you how I will handle your medical/mental health information. It describes how I use health information in this office, how it may be shared with other professionals and organizations, and how you may see the information. This information is important for you to know so that you can make the best decisions for yourself and your family. I am committed to maintaining the privacy of your personal health information as part of providing professional care. I am also required by state law and by professional ethics to keep your information private. If you have any questions or want to know more about anything in this Notice, please ask me.

2. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I need information about you and your conditions/concerns in order to provide care to you. You have to agree to allow me to collect, use, and share this information in order to provide appropriate care to you. Therefore, you must sign the Consent form before I begin treatment with you. I cannot treat you without your written consent. With your written informed *consent*, I may *use or disclose* confidential information (including, but not limited to your *protected health information*) (*PHI*), for *treatment, payment, and health care operations*. Other psychologist colleagues with whom I may consult or who may provide back-up coverage for after hours emergency calls when I am unavailable will also follow the practices described in this Notice. Please read the following for definitions of the bold-italicized terms.

* ***PHI (Protected Health Information)***- Individually identifiable health information received or created by me or my office. This includes information about your past, present and/or future health conditions, tests, and/or treatment you received from me or from others, and also about payment for healthcare. This information goes into your medical or healthcare record or file at this office.

* ***Treatment***- The psychological services or treatment you receive from me. It may include coordination, management, and other services related to your healthcare as well. I may consult with other professionals treating you, such as a physician or other mental health professional.

* ***Payment***- The reimbursement I receive for the services that I have provided. Information about you is needed to bill you, your insurance, or others in order to be paid for services. An example might be providing information such as dates of service, treatment planning and progress, and diagnostic information to your insurance carrier for reimbursement. Your insurance carrier may also be contacted to verify benefits or determine eligibility for coverage.

* ***Health Care Operations***- Operations refer to the performance and operation of my practice. Examples might include quality improvement activities, business audits, and administrative services.

* ***Use***- Activities involving your protected health information that occurs by me and within this office.

* **Disclosure-** Activities involving your protected health information that occurs outside of my office, such as releasing, sending, providing, or sharing that information with other parties outside of this office.

* **Consent-** Your consent and agreement to my office releasing your protected health information. You give your consent by reading and signing two separate forms for my practice: the “Acknowledgment and Consent” form as well as the “Professional Policies and Consumer Rights and Responsibilities” form.

3. Uses and Disclosures of PHI Requiring Authorization

The use or disclosure of your PHI for purposes outside of treatment, payment, or healthcare operations requires your written permission with an “Authorization” form. This authorization is above and beyond that obtained by your written consent. In circumstances in which I am asked to provide information regarding your treatment that is not for purposes of treatment, payment, or healthcare operations, I will need to obtain a written authorization from you before I release the information.

You may revoke an authorization of PHI or *psychotherapy notes* at any time. Each revocation must be written. Revocation cannot be retroactive; that is, I cannot take back information already disclosed or used in my office prior to the date an authorization was revoked.

* **Psychotherapy notes-** These are notes that I have made that are kept in written form in your chart for individual, conjoint, group, or family psychotherapy sessions and/or telephone contacts.

I will also obtain a written authorization from you before using or disclosing PHI:

- In a way that is not described in this Notice.
- For marketing purposes.

4. Uses and Disclosures of Your PHI that DO NOT REQUIRE your Consent or Authorization

There are some state and federal laws and professional ethical obligations that may require that I use or disclose PHI without your consent or authorization.

Child Abuse: If I have reasonable cause to believe that a child with whom I have had contact has been abused, or if I have reasonable cause to believe that an adult with whom I have had contact has abused a child, I may be required to report the abuse. In any child abuse investigation, I may be compelled to turn over PHI. I also have an ethical obligation to prevent harm to my clients and to others. I will use my professional judgment to determine whether it is appropriate to disclose or use PHI to prevent harm.

Other Abuse or Harm: I may have an ethical obligation to disclose or use your PHI to prevent harm to you or to others.

To Prevent a Serious Threat to Health or Safety: I may disclose confidential information when I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you upon yourself or another person. I must limit the disclosure of information to only the necessary amount of content and to only those individuals which would be consistent with the standards of the profession in addressing such problems.

Mentally Ill or Developmentally Disabled Adults: If I have reasonable cause to believe that a mentally ill or developmentally disabled adult who receives services from a community program or facility has been abused or that any person with whom I may come into contact has abused a mentally ill or developmentally disabled adult, I may be required to report the abuse. I also have an ethical obligation to prevent harm to my clients or others. I will use my professional judgment to determine whether it is appropriate to use or disclose PHI to prevent harm.

Legal Proceedings: If you are involved in a lawsuit or legal proceeding and the court orders your PHI be released or orders your mental evaluation. If you become involved in a lawsuit in which your mental or emotional condition is an element of your claim.

Worker’s Compensation: If you file a worker’s compensation claim, this constitutes authorization for me to release relevant PHI to involved parties and officials. This would include a past history of complaints or treatment of a condition similar to that involved in the worker’s compensation claim.

Health Oversight: The Oregon State Board of Psychologist Examiners may subpoena relevant records from me should I be the subject of a complaint.

Privacy Rule: When the use and disclosure without your consent is allowed under Section 164.512 of the Privacy Rule and Oregon's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as the state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

5. Client Rights Regarding Your Health Information

**Right to Request Restrictions:* You have the right to ask me to limit what PHI is used or disclosed to those others involved in your treatment or the payment of your treatment. However, I am not required to agree to the requested restrictions. If I do agree to the restriction, it will be in force except if it is against the law, in an emergency, or when the information is necessary to the treatment being provided to you.

**Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You may request that we communicate in a particular way or certain place that insures more privacy for you. For example, you may request calls only to a certain place or number, or you may request written correspondence sent to an address other than your home. I will try my best to accommodate such requests and may ask you to complete a form to facilitate this.

**Right to Inspect and Copy:* You have the right to look at and/or obtain a copy of PHI and psychotherapy notes contained in my treatment and billing records. There are some circumstances under which I may deny you access to the PHI. In such a circumstance, you may request from me more detailed information regarding the request and denial process and you may have my decision reviewed. I may bill you for a copy of the record.

**Right to Amend:* If you believe the information in your record is incorrect or missing important information, you can request to amend, or make some changes, to your health information. You must make this request in writing to me with the reasons you want to make the specific changes. I may deny the request. At your request, I will discuss further details of the amendment and denial process.

**Right to an Accounting:* You have the right to receive an accounting of disclosures of PHI for which you have not provided consent or authorization that occurred after April 14, 2003. At your request, details of the accounting process and appropriate forms will be discussed.

**Right to a Paper Copy:* You have a right to receive a paper copy of the Notice of Privacy Practices. If I change the document, a new copy will be available to view in the office and/or waiting area. You may also request a paper copy of updated versions from me.

**Right to File a Complaint:* If you believe that I have violated your privacy rights, please contact me as a first step. If you are not satisfied with our resolution, you may also file a written complaint with the Secretary of the Department of Health and Human Services. You may request the address from me.

**Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket:* You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

**Right to Be Notified if There is a Breach of Your Unsecured PHI:* You have a right to be notified if (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

6. Psychologist's Responsibilities

I am required by law to maintain the privacy of your PHI and to provide you with a notice of my legal duties and privacy practices with respect to your protected health information. I may change the privacy policies and practices described in this notice. Unless you are notified of such changes, I am required to abide by the terms in effect

under this notice. New notice policies and procedures are effective for all clinical information I already have about you as well as any information I receive in the future. If I revise my privacy practices and procedures, I will post a copy in my office with its effective date in the top right corner and will make a copy available to you upon your request.

7. **Effective Date:** The effective date of this notice is April 14, 2003.
Updated: August 6, 2013

8. **Questions:** If you have any questions regarding this notice, Please contact the Privacy Officer:
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