Rachel Maldonado, Psy.D.

**HIPPA PRIVACY NOTICE**

Notice of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information

HIPPA PROVIDES INDIVIDUALS WITH CERTAIN RIGHTS RELATED TO THEIR PROTECTED HEALTH INFORMATION (PHI), INCLUDING THE RIGHT TO REQUEST THEIR PHI BE KEPT CONFIDENTIAL. ALTHOUGH MINORS DO NOT GENERALLY HAVE THE AUTHORITY TO EXERCISE RIGHTS ON THEIR OWN BEHALF, STATE LAW AND HIPAA PROVIDE MINORS WITH THE AUTHORITY TO EXERCISE

CONTROL OVER CERTAIN CATEGORIES OF THEIR OWN PHI, INCLUDING OUTPATIENT MENTAL HEALTH TREATMENT FOR CHILDREN OVER THE AGE OF 12.

THIS POLICY DESCRIBES WHEN, AND UNDER WHAT CIRCUMSTANCES, THE MINOR’S HEALTH CARE PROVIDER MUST MAINTAIN THE CONFIDENTIALITY OF A MINOR’S PHI WHEN IT IS REQUESTED BY THE MINOR’S PERSONAL REPRESENTATIVE. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your child’s protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• “Minor” refers to an individual who is under 18 years of age, and who is neither married nor the parent of a child.

• “Minor's personal representative” is the minor's parent, legal guardian, or another with documentation proving he/she has legal custody of the minor (e.g., a stepparent who presents valid custody papers).

• “PHI” refers to protected health information, which is demographic and health information that could identify your child.

• “Treatment, Payment and Health Care Operations”

o Treatment is when I provide, coordinate or manage your child’s health care and other services related to your child’s health care. An example of treatment would be when I consult with another health care provider, such as your child’s physician or another psychologist.

o Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your child’s PHI to your health insurer to obtain reimbursement for your child’s health care or to determine eligibility or coverage.

o Health Care Operations are activities that relate to the performance and operation of my practice.

Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

• “Use” applies only to activities within my [office, clinic, practice group, etc.] such as sharing,employing, applying, utilizing, examining, and analyzing information that identifies your child.

• “Disclosure” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about your child to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked

for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization, or release of information, from you before releasing this information. You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the

authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

• Child Abuse: If, in my professional capacity, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or I have reasonable cause to suspect a child is abused or maltreated where the parent, guardian, custodian or other person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused

or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment, or the local child protective services agency. Further, if I reasonably believe a minor has been or is subject to domestic violence, abuse, and/or neglect by the minor's personal representative and that keeping the minor's PHI related to the abuse confidential is in the best interests of the minor, I may refuse to release or provide access to the minor's abuse-related PHI to the minor's personal representative.

• Health Oversight: If there is an inquiry or complaint about my professional conduct to the New York State Board for Psychology, I must furnish to the New York Commissioner of Education, your child’s confidential mental health records relevant to this inquiry.

• Judicial or Administrative Proceedings: If your child is involved in a court proceeding and a request is made for information about the professional services that I have provided him/her and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when your child is being evaluated by a third party or where the evaluation is court ordered.

I must inform you in advance if this is the case.

• Serious Threat to Health or Safety: I may disclose your confidential information to protect your child or others from a serious threat of harm by your child. Worker’s Compensation: If your child file a worker’s compensation claim, and I am treating your child for the issues involved with that complaint, then I must furnish to the chairman of the Worker’s Compensation Board records which contain information regarding your psychological condition and treatment.

IV. Patient's Rights and Psychologist's Duties

Patient’s Rights:

• Minor’s Right to Consent to Treatment. A minor who is over the age of twelve (12) may seek and receive mental health outpatient services independently from his/her personal representative. (Parental consent is not required.) The minor's personal representative does not have the right to the minor's PHI if the minor alone consented to the treatment, unless the minor authorizes the release.

• Right to Request Restrictions: As your child’s personal representative, you have the right to request restrictions on certain uses and disclosures of protected health information about your child. However, I am not required to agree to a restriction you request for your child.

• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that your child is seeing me. Upon your request, I will send his/her bills to another address.)

• Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in your child’s mental health and billing records used to make decisions about your child for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

• Right to Amend: You have the right to request an amendment of your child’s PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

• Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

• Right to a Paper Copy: You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist’s Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my policies and procedures, I will provide you with an updated copy if your child is still in therapy with me. If we have ended therapy, you may request an updated copy to be sent to you by mail.

V. Questions and Complaints

If you are concerned that I have violated your child’s privacy rights, or you disagree with a decision I made about access to your child’s records, please contact Rachel Maldonado, Psy.D. at 917.727.8269 or DrRachelMaldonado@gmail.com about your concerns. If you do not feel comfortable doing this, you may call The New York State Psychology Licensing Board at 1-800-442-8106 or send an email to conduct@mail.nysed.gov with your questions or a complaint. You may also address your complaints to the Secretary of the U.S. Department of Health and Human Services by obtaining their contact information on their website at [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa).

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on September 9, 2009. I reserve the right to change the terms of this notice and to make the new notice provisions effectivefor all PHI that I maintain. I will provide you with a revised notice by providing you with a paper copy at our next session from the date of revision. If your child is no longer in therapy, I will provide a revised notice only at your written request.

VII. Consent for Treatment

I have read and understood this policy statement. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to have my child participate in this intake evaluation and/or treatment. I understand that I may withdraw my child from treatment at any time.

Name of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Personal Representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Personal Representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rachel Maldonado, Psy.D. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s personal representative has received a copy for their records on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (to be filled out by Dr Maldonado)