# Notice of Privacy Practices and Policies

**With effect from Jan 2023**

**Sam Mathew MSN, MA, PMHNP-BC**

**17220 127TH PL NE # 304 Woodinville, Washington 98072, Tel. 4252298338**

**Please carefully review this notice, which explains how your health care information may be utilized and disclosed in accordance with federal legislation, as well as how you can access this information.**

This notice is applicable to all the records, both paper and electronic, related to your medical care, which are under the custody of Sam Mathew PMHNP. These records include those created by Sam Mathew PMHNP, as well as any obtained from external sources, such as other healthcare providers involved in your treatment and laboratory reports.

Here are the various manners in which the practice may utilize and disclose your information:

The following categories outline the ways in which your confidential information may be used and shared. This includes Protected Health Information (PHI), which refers to information that could potentially identify you. It's important to note that not every use or disclosure within a category is listed, but all permitted uses and disclosures fall under these categories.

**Routine Situations:**

**a. For Treatment:** Your information may be used to provide medical treatment or services to you. This includes coordinating and managing your healthcare, such as consulting with other healthcare providers involved in your care, like your primary care physician.

**b. For Payment**: Information about you may be used and disclosed to facilitate billing and payment for the treatment and services you receive at the practice. This may involve sharing your information with insurance companies, third parties, and, if necessary, collection agencies. For example, your health plan may be informed about the services you received at the practice to ensure payment or reimbursement.

**For Health Care Operations:**

I may utilize and disclose your information for administrative functions that are necessary to run my practice and ensure high-quality care. This may involve using your information, either individually or combined with other patient data, to evaluate the effectiveness of treatments and services, assess my performance in providing care, and make decisions regarding additional services offered by my practice. When feasible, any identifying information will be removed. I may share information with business associates who provide essential services for the operation of my practice, such as transcription companies or billing services. These third parties will be contractually bound to protect your information in the same way I would. Additionally, I may allow your health plan or other providers to review records containing your information to assist them in improving the quality of service provided to you.

**Communicating with You and Others Involved in Your Care:**

My practice may contact you to provide appointment reminders or share information about treatment alternatives, as well as other health-related benefits and services that may be of interest to you. In certain circumstances, with your permission, I may share information about you with a friend or family member who is involved in your care or payment for your care. However, if you have explicitly requested that such disclosures not occur and I have agreed, your preferences will be respected. The information disclosed will be directly relevant to the person's involvement in your care or payment for your care, and whenever possible, you will identify that person. In emergency situations or instances where you are unable to indicate your preference, I may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

Initials_____ Date_____

**SPECIAL SITUATIONS:**

**As Required by Law:** I am obligated to disclose your information when federal, state, or local laws require me to do so. This may include releasing information in response to a valid subpoena or for reporting communicable diseases.

**Health Oversight Activities:** I may disclose your information to a health oversight agency as authorized by law. These activities, such as audits, investigations, inspections, and licensure, are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

**For Judicial or Administrative Proceedings**: If you are involved in a court proceeding and there is a request for information about the professional services you received from my practice, such information may be privileged under state law. I will not release information without written authorization from you or your legal representative unless a subpoena has been properly issued and you have not opposed it within the specified format and timeframe. Additionally, if a court order compels me to provide PHI, I am required to comply. Please note that this privilege may not apply when you are being evaluated for a third party or if the evaluation is court-ordered. You will be informed in advance if this is the case.

**To Avert Serious Threat to Health or Safety:** I may disclose your confidential mental health information without authorization if I reasonably believe that it will prevent or minimize imminent danger to your health, safety, or the safety of others. This may involve reporting threats of harm to law enforcement officials or taking necessary measures to protect potential victims of a violent crime.

**Regarding Worker's Compensation,** unless specified otherwise, I am required to provide access to all relevant Protected Health Information (PHI) related to the specific injury, as determined by the Washington Department of Labor and Industries. This information will be made available to your employer, your representative, and the Department of Labor and Industries upon request, at any point during the proceedings.

**Under the circumstances of public health,** I am authorized to share your information as mandated by law. Such instances typically involve the following activities, among others:

- Taking necessary measures to prevent or manage disease, injury, or disability.
- Reporting incidents of child abuse or neglect.
- Reporting cases of adult and domestic abuse.
- Reporting adverse reactions to medications or issues with products.
- Informing individuals about product recalls that may affect them.
- Notifying individuals who may have been exposed to a disease or are at risk of contracting or transmitting a disease or condition.
- If we have reason to believe that a patient has been subjected to abuse, neglect, or domestic violence, we are obligated to inform the relevant government authority.

**Law Enforcement**: In the event of a request from a law enforcement official, I may disclose information about you under the following circumstances:

- Compliance with a court order, subpoena, warrant, summons, or a similar legal procedure.
- To aid in the identification or location of a suspect, fugitive, material witness, or missing person.
- If you are suspected of being a victim of a crime, generally with your consent:
- Regarding a death that we believe may be the result of criminal behavior.
- Concerning criminal behavior at the hospital.
- In emergency situations, to report a crime, including the crime location or victims, as well as the identity, description, or whereabouts of the perpetrator.

Initials_____ Date_____

**AUTHORIZATIONS ARE REQUIRED FOR THE FOLLOWING DISCLOSURES:**

Psychotherapy notes are subject to separate HIPAA regulations and have additional protections. Typically, an authorization is needed for any use or disclosure of psychotherapy notes, except for treatment, payment, or healthcare operations as well as routine situations listed. Other circumstances require a valid authorization from you for the use and disclosure of confidential information. Payment and healthcare operations-related information may be shared only with health plans, their agents, and the practice's business associates. Note that life insurance companies, automobile insurance companies, and workers' compensation carriers are not covered under HIPAA, and if you want information to be shared with any of these companies, an authorization is required, unless mandated by state or federal law.

Your patient rights include the following:

- The right to request restrictions on certain uses and disclosures of your information.
- The right to request confidential communications in a specific manner or location.
- The right to inspect and obtain copies of your medical and billing records (excluding psychotherapy notes, information for legal actions, and certain confidential laboratory tests under CLIA).
- The right to request amendments to incorrect or incomplete information.
- The right to receive an accounting of disclosures of your confidential information.
- The right to obtain a paper copy of the Notice of Privacy Practices upon request.

My practice's duties include protecting your confidential information and notifying you of any changes to privacy measures. I am required by law to maintain the privacy of your confidential information and abide by the terms of the Notice of Privacy Practices.

Changes to the Notice of Privacy Practices may occur, and the revised provisions will be effective for all maintained confidential information. A copy of the current Notice will be available in my practice, and any changes will be indicated for six months. If you believe your privacy rights have been violated, you can file a complaint with me or the Secretary of the Department of Health and Human Services.

Any other uses or disclosures of information not covered by the notice or applicable laws will require your written permission. You have the right to revoke any previously given permission in writing, but disclosures made prior to the revocation will remain valid. Additionally, I am required to retain records of the care provided to you.

PRIVACY OFFICER

I serve as the privacy officer for my practice, and you can contact me with any questions or comments regarding privacy matters. Sam Mathew MSN, MA, PMHNP-BC, 17220 127$^{TH}$ PL NE # 304 Woodinville, Washington 98072, Tel. 4252298338

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy (three pages) of the Notice of Privacy Practices from Sam Mathew MSN, MA, PMHNP-BC at the address specified above.

Patient Signature: _____ Patient Name: _____Date: