

# UTAH HIPAA NOTICE FORM

## Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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.

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

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

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
  - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - 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 practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my practice such as releasing, transferring, or providing access to information about you 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 from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) 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 I have reason to believe that a child has been subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, or I observe a child being subjected to conditions or circumstances which would reasonably result in sexual abuse, physical abuse, or neglect, I must immediately notify the nearest peace officer, law enforcement agency, or the Office of the Utah Division of Child and Family Services.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult (defined below) is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Utah Adult Protective Services intake, or the nearest law enforcement agency as soon as I become aware of the situation. A “vulnerable adult” means an elder adult, or an adult who has a mental or physical impairment which substantially affects his or her ability to: (a) provide personal protection; (b) provide necessities such as food, shelter, clothing, or mental or other health care; (c) obtain services necessary for health, safety, or welfare; (d) carry out the activities of daily living; (e) manage his or her own resources; or (f) comprehend the nature and consequences of remaining in a situation of abuse, neglect, abandonment or exploitation.
- **Health Oversight:** If you file a complaint against me with the Utah Division of Occupational and Professional Licensing, I may disclose to them information from your records relevant to the complaint.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your personal or legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case
- **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records which is essential to protect the rights and safety of others. I also have such a duty if you have a history of physical violence of which I am aware and I have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person. If communicable disease is reported to me, I am required to report that disease to the Utah State Department of Health. Reportable communicable diseases include: AIDS, Hepatitis, Sexually Transmitted Diseases and Smallpox.
- **Worker's Compensation:** If you file a worker's compensation claim, I must furnish mental health records to: (1) you or your dependents, (2) your employer, (3) the employer's workers' compensation insurance carrier, (4) the Uninsured Employers' Fund, (5) the Employers' Reinsurance Fund, (6) the Labor Commission, and (7) any attorney representing any of the above in an industrial injury or occupational disease claim.

#### **IV. Patient's Rights and Psychologist's Duties**

##### **Patient's Rights:**

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *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 you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you 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 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 regarding you. 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 the 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 promptly distribute to my clients in session the revisions whenever there is a material change to uses and disclosures, client's rights, my legal duties, or other privacy practices stated.

#### **V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Steve Smith, Ph.D., Psychologist at 801-422-3035.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

#### **VI. Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on April 15, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice through my contact with you in session.

03/14/2010

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**Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information**

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

**II. Uses and Disclosures Requiring Authorization**

**III. Uses and Disclosures with Neither Consent nor Authorization**

**IV. Patient's Rights and Psychologist's Duties**

**V. Complaints**

**VI. Effective Date, Restrictions and Changes to Privacy Policy**

This Notice Described How Psychological And Medical Information About You May Be Used And Disclosed And How You Could Get Access To This Information. I Was Asked To Review It Carefully. Further, I Received A Copy Of The Form That Included Details On The Subject Headings Listed Above.

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Name of Client (Please Print)

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Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date