

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC at 8158 E. 5th Ave. Ste 200; Denver, CO 80230

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC at 7581 E. Academy Blvd. Ste 209; Denver, CO 80230 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

Client Request for Restriction on Use or Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations

The privacy of your Protected Health Information is protected by HIPAA, the NASW Code of Ethics, and State Social Worker Confidentiality Rules. However, Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC is permitted by HIPAA to use and disclose your protected health information, with certain limits and protections, for treatment, payment and health care operations activities. Pursuant to HIPAA, you have the right to request restrictions on Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC's use and disclosure of your protected health information for treatment, payment or health care operations activities. Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC is not required to agree to your request for restrictions, but if Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC does agree to your request, it is bound by that agreement and cannot use or disclose your protected health information in a manner inconsistent with an agreed-upon restriction.

Today's Date: _____

Name Date of Birth

Address

Daytime Telephone Evening Telephone

I request that Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC restrict the use and disclosure of my protected health information ("PHI") for purposes of treatment, payment or healthcare operations as follows:

1. I understand that Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC is not required by HIPAA to agree to this restriction, unless the restriction concerns a disclosure to a health plan for purposes of carrying out payment or health care operations and such disclosure is not otherwise required by law and the restriction concerns PHI which pertains solely to a health care item or service for which Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC has been paid out of pocket by me in full.

2. If Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC agrees to this restriction, I understand the restriction may be terminated at any time if permitted by social work ethical and state social worker confidentiality rules. A termination of this restriction is effective for PHI that Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC creates or receives after the date it informs me of such termination. Restrictions concerning a disclosure to a health plan for purposes of carrying out payment or health care operations where such disclosure is not otherwise required by law and concerns PHI which pertains solely to a health care item or service for which Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC has been paid out of pocket by me in full will not be terminated unless I request such termination in writing.

3. Even if the request is granted, I understand that restricted PHI may be used or disclosed to provide emergency treatment for me or as otherwise required by law. However, the emergency treatment provider will be asked not to redisclose any restricted PHI.

4. I understand that in accordance with other applicable law, the types of uses and disclosures I have written above may or may not be otherwise permitted.
5. I also understand that my right to request restrictions under this HIPAA provision only extends to use or disclosure for treatment, payment or health care operations. My right to authorize the use and disclosure of protected health information for other purposes {or to withhold consent} is addressed in separate policies and the HIPAA Notice of Privacy Practices.
6. I will be notified in writing of the action taken on this request. If a request is not specifically listed above and agreed to in writing, it will not be effective.

Signature of Patient _____ Date _____

Signature of Patient's Personal Representative (if applicable) _____ Date _____

For Organization Use Only:

Date Request Received: _____

Date of Written Response: _____

Action taken (CHECK ONE): 111 Granted 111 Denied (if denied, state reason below)

Joanna C. Ioannides, LCSW

Lowry Counseling, LLC

Lowry Counseling, LLC
Joanna C. Ioannides, LCSW

**Authorization
Contact by Telephone or Verbally in Event of Breach of PHI**

I, _____ [Insert Name of Patient/Client], authorize Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC. Such conversation shall be documented by Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC.

Signature of Patient/Client

Date

Signature of Parent, Guardian or Personal Representative

Date

Release of Information

I, _____ [Insert Name of Patient/Client], whose Date of Birth is _____,

authorize [JOANNA C. IOANNIDES, LCSW/ LOWRY COUNSELING, LLC at 7581 E. Academy Blvd. Ste 200; Denver, CO 80230 ph. (720)319-7319 fax (303)379-4607] to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment	_____ Educational Information
_____ Diagnosis	_____ Discharge/Transfer Summary
_____ Psychosocial Evaluation	_____ Continuing Care Plan
_____ Psychological Evaluation	_____ Progress in Treatment
_____ Psychiatric Evaluation	_____ Demographic Information
_____ Treatment Plan or Summary	_____ Psychotherapy Notes*
_____ Current Treatment Update	(*Cannot be combined with any other disclosure)
_____ Medication Management Information	_____ Other _____
_____ Presence/Participation in Treatment	_____ Other _____
_____ Nursing/Medical Information	

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than marketing, sale of information, research or as specified above, please specify:

Marketing

- If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by the [Social Work Organization] in exchange for disclosing the information. \$ _____

Sale of Information

- If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.

Research

- If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to JOANNA C. IOANNIDES, LCSW/ LOWRY COUNSELING, LLC at 7581 E. Academy Blvd. Ste 209; Denver, CO 80230/ ph. (720)319-7319 fax (303)379-4607. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: _____

Conditions

I further understand that Joanna C. Ioannides, LCSW/ Lowry Counseling, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

____ Check here if patient/client refuses to sign authorization

Signature of Staff Witness Date