

Notice of Privacy Practices

This notice describes how medical and mental health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

It is my professional and ethical responsibility to assure you that I will hold your personal information in the strictest confidence. I am required by applicable Federal and State of Washington law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligation, and your rights concerning your health information (Protected Health Information, or "PHI"). I must follow the privacy practices described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written Authorization:

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes and Reports, as described in Section II, for certain purposes described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under Federal and State of Washington law.

1. *Treatment*: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment. This includes clinical supervisors and case consultants who assist in my professional development and are bound to mental health confidentiality laws. I participate in case consultation with Bob Edelstein so that I may provide high quality services for your benefit. Mr. Edelstein's contact information is available upon request.
2. *Health care operations*: I may use and disclose PHI in connection with my health care operations, including accreditation, certification, licensing, or credentialing activities. I will notify you in advance of any such disclosure.
3. *Required or permitted by law*: I may use or disclose PHI when I am required or permitted to do so by law, or in the following situations:
 - a. *Duty to warn*: Your PHI may be disclosed if I determine I need to alert an intended victim of a serious threat to their health. For example, this may occur if you reveal intentions to kill or harm another person. I am obligated to take necessary action to avert a serious threat to the health or safety of others.
 - b. *Danger to self*: Your PHI may be disclosed if I determine that you may kill or seriously harm yourself. For example, this may occur if you reveal that you are planning to commit suicide. I am obligated to take necessary action to avert a serious threat to your health or safety.
 - c. *Child or elder abuse or neglect*: Your PHI may be disclosed if you report or I reasonably suspect any child or elder abuse or neglect. For example, if you reveal that you have physically harmed a child then I will need to notify Child Protective Services (CPS).
 - d. *Court order*: Your PHI may be disclosed if I am presented with a court order to do so. For example, this may occur if you have any legal involvement and a judge or law enforcement agency has called me to testify or release records.
 - e. *Crime against me or within my office premises*: Your PHI may be disclosed if you commit or threaten to commit a crime against me or within my office premises. This includes damage to property.
 - f. *Other disclosures*: Your PHI may be disclosed for public health activities or health oversight activities, including disclosures to State or Federal agencies authorized to access PHI. Your PHI may be disclosed for research when approved by an institutional review board, to military or national security agencies, coroner, medical examiners, and correctional institutions or otherwise as authorized by law. Your PHI may be disclosed to necessary parties if you file a legal or administrative claim against me. Your identifying information may be disclosed to debt collection agency personnel if you fail to pay for my professional services by our agreed upon time period.

B. Uses and Disclosures Requiring Your Written Authorization:

1. *Psychotherapy notes:* Notes recorded by me documenting the contents of a counseling session with you (“psychotherapy notes”) will be used only by me and will not otherwise be used or disclosed without your written authorization.
2. *Marketing communications:* I will not use your health information for marketing communications without your written authorization.
3. *Payment:* I may not disclose PHI to your insurance company for payment purposes without your written authorization.
4. *Other Uses and Disclosures:* Uses and disclosures other than those described in Section I-A above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, to your attorney, or to your health care providers. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy: You may request access to your medical and/or billing records maintained by my office in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. Otherwise, this information must be released within fifteen (15) days. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor thirteen (13) years of age or older, please note that certain portions of the minor’s medical record will not be accessible to you, such as records relating to mental health treatment (age 13 and older), substance abuse treatment (age 16 and older), sexually transmitted diseases (age 14 and older), or abortions (age 14 and older), unless your minor child has provided written authorization to do so.

B. Right to Alternative Communications: You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment, or health care operations. You must request any such restriction in writing, addressed to me. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by me. This right applies to disclosures for purposes other than treatment, payment of health care operations, and excludes disclosures made to you or disclosures otherwise authorized by you and is subject to other restrictions and limitations. It is my obligation to inform you if there are any unauthorized releases of your PHI by me. If a breach of your PHI has been made, I will explain the possible scope of the disclosure, the risks associated, and the steps I have taken/will take to deal with the breach.

E. Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing and it must explain why the information should be amended. I must respond to your request within ten (10) days. I may deny your request under certain circumstances. In this event, a “Statement of Disagreement,” based upon your proposed amendment, must be added to your record.

F. Right to Obtain Notice: You have the right to obtain a paper copy of this Notice.

G. Questions and Complaints: If you desire further information about your privacy rights, or you are concerned that I have violated your privacy rights, you may contact me, Tacy L. Muzzy, MS, LMHC, by telephone at (509) 735-5088 or in writing at 1030 N. Center Parkway, Suite 101, Kennewick, WA 99336. You may also file written complaints with the Director of the Office of Civil Rights of the U.S. Department of Health and Human Services, or with the state Department of Health, Health Professions Quality Assurance Division at (360) 236-4900, P.O. Box 47869, Olympia, WA 98504. You may also contact the ombuds. Contact information for the ombuds can be found by visiting <https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/ombuds-services>, choosing “contact your local ombuds,” and finding the phone number for your particular ombuds.

If you lodge a complaint or grievance, you will be entitled to a fair hearing and be free of any act of retaliation by me.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. **Effective Date:** This Notice is effective on 1 January 2022.

B. **Changes to this Notice:** I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for PHI that I maintain, including any information created or received prior to issuing the new Notice. If I change this Notice, I will inform you, and you may obtain any revised Notice by contacting me.

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I _____, acknowledge that I received a copy of the Notice of Privacy Practices for *Tacy L. Muzzy, MS, LMHC*.

This Notice of Privacy Practices describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of health care system operations.

*The Notice of Privacy Practices also describes my individual rights and responsibilities and the exercise thereof, and the duties of *Tacy L. Muzzy, MS, LMHC*, with respect to my protected health information.*

*I understand that *Tacy L. Muzzy* reserves the right to change the terms of this Notice of Privacy Practices and to make changes regarding all protected health information resident at/or controlled by *Tacy L. Muzzy*.*

Client Signature

Date

Note: This form will be retained in the mental health record.

***** FOR OFFICE USE ONLY *****

I attempted to obtain a signed Acknowledgment of Receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained for the following reason:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented me from obtaining Acknowledgment
- Other: _____
