



PAUL BAXTER, L.M.H.C., M.A.

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**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 Paul Baxter, M.A., RMHC

Signature of Client *(or Legal Guardian)*: _____ Date: _____

If a personal representative signs this acknowledgement on behalf of the client, please complete the following:

Name of Personal Representative:

Relationship to Client: _____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other *(Please specify)*-

NOTICE OF PRIVACY PRACTICES

THIS DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information (also called “Protected Health Information” or “PHI”). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for the 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 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 services to you. In addition, I may disclose PHI to other health care providers involved in your treatment.
2. **PAYMENT:** I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health insurance provider. For example, I may disclose PHI to enable your health insurance provider to take certain actions before it approves or pays for treatment services.
3. **HEALTH CARE OPERATIONS:** I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, and licensing or credentialing activities.
4. **REQUIRED OR PERMITTED BY LAW:** I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; disclosures to health and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions, or otherwise as authorized by law.

B. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

1. **PSYCHOTHERAPY NOTES:** My notes 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. **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, or to your attorney. 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 record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under some circumstances, I may deny access to your records. I may charge a fee for the cost of copying and sending you any records requested. *[Note: State law may regulate such charges.]* If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you. *[Note: Examples should be included consistent with state law (e.g., records related to mental health, drug treatment, or family planning services).*

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 as indicated below. 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, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. RIGHT TO REQUEST AMENDMENT. You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. RIGHT TO OBTAIN NOTICE. You have the right to obtain a paper copy of this Notice by submitting a request to me at any time.

G. QUESTIONS AND COMPLAINTS. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact me at 425-736-1676. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the director or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. EFFECTIVE DATE. This Notice is effective on January 2008.

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 all PHI that I maintain, including any information created or received prior to issuing the new notice. You may also obtain any revised notice by contacting me.