McClintock Mental Health, PLC

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EFFECTIVE DATE OF THIS NOTICE This notice went into effect on 4/8/2023

NOTICE OF PRIVACY PRACTICES

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

If you have questions about this notice, please contact me.

This notice describes my policies and practices and that of,

•Any health care professional authorized to enter information into your health record.

•All employees, staff and other personnel.

MY PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you and your health is personal. We are committed to protecting your privacy and health information about you. We create a record of the care and services you receive here. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by us, whether made by us or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain. obligations we have regarding the use and disclosure of health information.

We are required by law to:

•Make sure that health information that identifies you is kept private;

•Give you this notice of our legal duties and privacy practices with respect to health information about you; and

•Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed.

For Treatment. We may use health information about you to provide you with treatment or services. We may disclose information about you to doctors, nurses, clinicians, case managers, interns, or others who are involved in providing services to you. For example, a clinician might be treating you for a mental health problem and need to talk with a psychiatrist or another consultant who has specialized training in a particular area of care. We may also disclose information about you to people outside our office who may be involved in your health care.

For Payment. We may use and disclose health information about you so that the treatment and services you receive may be approved by, billed to, and payment collected from a third party such as an insurance company. For example, we may need to give your health plan information about counseling you received here so your health plan will pay us or reimburse you for a counseling session. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the service/treatment.

For Health Care Operations. We may use and disclose health information about you for our operations. These uses and disclosures are necessary to run our practice and make sure that all individuals receiving services from us receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in serving you. We may also combine health information about many consumers to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, clinicians, case managers, interns and others for review and learning purposes.

We may also combine the health information we have with health information from other mental health agencies to compare how we are doing and to see where we can make improvements in the services we offer. We will remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific consumers are.

Appointment Reminders. We may use and disclose information to contact you as a reminder that you have an appointment.

Alternative Treatment and Benefits and Services. We may use and disclose information about you in order to obtain and recommend to you other treatment options and available services as well as other health-related benefits or services.

As Required by Law. We will disclose health information about you when required to do so by federal, state or local law. In Vermont, this would include: victims of child abuse; the abuse, neglect or exploitation of vulnerable adults; or where a child under the age of sixteen is a victim of a crime; and firearm-related injuries.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans. If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs as authorized by Vermont Law. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:

1. To prevent or control disease, injury or disability;

2. To report deaths;

3. To report child abuse or neglect;

4. To report abuse, neglect or exploitation of vulnerable adults; any suspicion of abuse, neglect or exploitation of the elderly (age 60 or older), or a disabled adult with a diagnosed physical or mental impairment, must be reported;

5. To report reactions to medications or problems with products;

6. To notify individuals of recalls of products they may be using;

7. To notify an individual who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, but are not limited to, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Legal Proceedings and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.

Public Health Officials and Funeral Home Directors., We may release information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors thereby permitting them to carry out their duties.

Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the services that we provided to you.

YOUR RIGHTS REGARDING INFORMATION ABOUT YOU

Any reasonable assistance (physical, communicative, etc.) that you require in order to exercise your rights will be provided to you by us.

You have the following rights regarding information we maintain about you:

Right to Review and Copy. You have the right to review and copy health information that may be used to make decisions about your care. This may include both health and billing records.

To review and copy health information that may be used to make decisions about you, you must submit your request in writing to us. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny or limit access to your request to inspect and copy in certain very limited circumstances. If you are denied or limited access to health information, you may request that the decision be reviewed. Another health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us.

To request an amendment, your request must be made in writing to us. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support that request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

2. Is not part of the designated record set kept by or for us;

3. Is not part of the information which you would be permitted to inspect and copy; or,

4. Was determined accurate or complete by us.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you.

To request this list or accounting of disclosures, you must submit your request in writing to us. Your request must state a time period which may not be longer than six years and may not include dates before April 1, 2004. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you for the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member. For example, you could ask that we not use or disclose information about a counseling session you received.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to us. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to us. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of the current notice at any time. To obtain a paper copy of this notice contact us.

SECURITY OF HEALTH INFORMATION

Due to the nature of our mental health practice, we may possess individually identifiable information beyond the physical security of our offices. In these situations, we will ensure the security and confidentiality of the information in a manner that meets our policies, State and Federal Law.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain on each page, in the top right-hand corner, the effective date. In addition, should we make a material change to this notice, we will, prior to the change taking effect, publish an announcement of the change at our office.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services.

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

The Secretary of the Department of Health and Human Services can be contacted through their regional office at Office of Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building - Room 1875, Boston, Massachusetts 02203, voice phone (617) 565-1340, fax (617) 565-3809, TDD (617) 565-1343.

Consent & Agreement to the Use & Disclosure of Health Information

For Treatment, Payment or Healthcare Operations

I understand that as part of my care, you originate and maintain records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment;

2. A means of communication among the professionals who contribute to my care;

3. A source of information for applying my diagnosis and information to my bill;

4. A means by which a third-party can verify that services billed were actually provided; and,

5. A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals and the services that are offered.

I have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures (release of, or access to, my information). I understand that I have

the right to review the notice prior to signing this consent. I understand that you reserve the right to change your notice and practices. However, prior to a material change taking effect, you will publish an announcement of the change at your office. Should the *Notice of Privacy Practice* be materially changed, you will provide me a copy of the new *Notice.*

I understand that my records are subject to confidentiality imposed by state and federal regulations. I also understand that alcohol and drug abuse client records are protected by 42 CFR, Part 2, and that records may not be released or disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that you are not required to agree to the restrictions requested, however if you agree to the requested restrictions, you are bound by our agreement.

By signing this form, I consent to your use and disclosure of protected health information about me for treatment, payment and health care operations. I understand that I may revoke this consent in writing, except to the extent that you have already taken action based upon my prior consent.