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HIPAA Notice of Privacy Practices

PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact Lisa A. Paquette, LMHC at the above phone or email address.

In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; therefore, I will do all I can do to protect the privacy of your mental health records. If you have questions regarding matters discussed in this Patient Notification, please do not hesitate to ask.

PRACTICE OBLIGATIONS: I am required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of the notice that is currently in effect.

EFFECTIVE DATE OF THIS NOTICE This notice went into effect on March 18, 2024

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING: If you request me to send any of your protected health information of any sort to anyone outside of my practice, you must first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon request. In recognition of the importance of the confidentiality of conversations between therapist and patients in treatment settings, HIPAA permits keeping “psychotherapy notes” separate from the overall “designated medical record”. “Psychotherapy notes” are the therapist’s notes “recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, couples, or joint family counseling session and that are separated from the rest of the individual’s medical record.” “Psychotherapy notes” are private and contain information about you and your treatment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways I may use and disclose health information that identifies you.

DISCLOSURES REQUIRING YOUR AUTHORIZATION:

Treatment. With your Authorization. I may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, I may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside this practice, who are involved in your medical care and need the information to provide you with medical care.

Individuals Involved in Your Care or Payment for Your Care. With your authorization. When appropriate, I may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend, or anyone else you designate.

Court involvement. With your authorization. In response to summaries of attendance requested by DCF or Probation officers.

Workers' Compensation. With your authorization. I may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

DISCLOSURES NOT REQUIRING AUTHORIZATION:

Payment. I may use and disclose Health Information so that I or others may bill and receive payment from you, an insurance company or a third-party biller for the treatment and services you received. For example, I may give your health plan information about you so that they will pay for your treatment.

Health Care Operations. I may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of my patients receive quality care and to operate and manage my practice. For example, I may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. I may use and disclose Health Information to contact you to remind you that you have an appointment with me. I also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you, or to refer you to these services at your request.

As Required by Law. I will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. I may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. I also may notify your family about your location or general condition or disclose such information to an entity assisting in a crisis or disaster relief effort.

Reporting Abuse. I may be required to disclose your health information if I suspect or am told of the abuse of children, elderly over age 60 or vulnerable adults. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Safety. If a client communicates a threat, or I believe a client to present a threat of imminent serious physical violence against a readily identifiable individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police or seeking hospitalization for the client. Likewise, If I believe a client presents a threat of imminent serious physical harm to oneself, I may be required to take protective actions. These actions may include contacting the police or others who can assist in protecting the client or seek hospitalization for the client. I make every effort to fully discuss this with you before taking any action.

Business Associates. I may disclose Health Information to my business associates that perform functions on my behalf or provide me with services if the information is necessary for such functions or services. For example, I may use another company to perform billing services on my behalf. My business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information as specified in our Business Associates Agreement.

Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

Public Health Risks. I may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; a person who may have been exposed to a disease or may be at risk for

contracting or spreading a disease or condition; and the appropriate government authority if I believe a patient has been the victim of abuse, neglect or domestic violence. I will only make this disclosure if you agree and give authorization or when required or authorized by law.

Health Oversight Activities. I may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, 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.

Data Breach Notification Purposes. I may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, I may disclose Health Information in response to a court order. I also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. I may also disclose health information in defending myself in legal proceedings instituted by a you.

Law Enforcement. I may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, I am unable to obtain the person's agreement; (4) about a death I believe may be the result of criminal conduct (5) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Inmates or 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 to the correctional institution or law enforcement official. This release would be if 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) the safety and security of the correctional institution.

Marketing and sale of information. As a Counselor I will not use or disclose your personal health information for marketing purposes. I also will not sell your personal health information in the regular course of my business.

If you do give me an authorization via a release of information, you may revoke it at any time by submitting a written revocation to Lisa A. Paquette, LMHC 1120 Somerset Ave Unit 413, North Dighton, MA 02764 and I will no longer disclose Protected Health Information under the authorization. However, any disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information I have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Lisa A. Paquette, LMHC 1120 Somerset Ave Unit 413, North Dighton, MA 02764. I will have up to 30 days to make your Protected Health Information available to you and I may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. I may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. I may deny your request in certain limited circumstances. If I do deny your request, you have the right to have the denial reviewed by a licensed

healthcare professional who was not directly involved in the denial of your request, and I will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. I will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either my standard electronic format or if you do not want this form or format, a readable hard copy form. I may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information I have is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment for as long as the information is kept by my practice. To request an amendment, you must make your request, in writing, to Lisa A. Paquette, LMHC 1120 Somerset Ave Unit 413, North Dighton, MA 02764.

Accounting of Disclosures. You have the right to request a list of certain disclosures that were made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Lisa A. Paquette, LMHC 1120 Somerset Ave Unit 413, North Dighton, MA 02764.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Lisa A. Paquette, LMHC 1120 Somerset Ave Unit 413, North Dighton, MA 02764.

I am not required to agree to your request unless you are asking me to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid privately “out-of-pocket” in full. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid privately, out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by a certain email or at work. To request confidential communications, you must make your request, in writing, to Lisa A. Paquette, LMHC 1120 Somerset Ave Unit 413, North Dighton, MA 02764. Your request must specify how or where you wish to be contacted. I will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask me to mail you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice email lisapaquettelmhc@outlook.com.

CHANGES TO THIS NOTICE: I reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. I will post a copy of our current notice on my website. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint. To file a complaint, contact Lisa A. Paquette, LMHC 1120 Somerset Ave Unit 413, North Dighton, MA 02764. All complaints must be made in writing. You will not be penalized for filing a complaint.