**Kevin Karl, LCSW, PLLC**
**911 Barret Avenue, Louisville, Kentucky 40204  502-640-4536**

# Notice of Privacy Practices

I place a high value on respecting the privacy of clients and their health information. The federal government has created a set of regulations to protect this right as well. This notice describes how protected health information about you may be used or disclosed and how you can get access to this information. It tells you about your rights and my responsibilities to protect the privacy of your personal health information. It also tells you what to do if you believe that I have violated any of your rights or any of our responsibilities. **Please review the information in this notice carefully.**

I will notify you if I change this notice at your next appointment. If this notice is revised, a copy of the revised notice will be available upon request and posted on my website. Changes to my practices may apply to health information we already have about you as well as any new information.

## How I Use or Disclose Your Protected Health Information

I am required by law to maintain the privacy of your Protected Health Information. However, a client's information may be communicated via telephone or faxed as needed to facilitate treatment/services, payment/insurance verifications, and other operational issues. In these situations, reasonable efforts will be made to safeguard the exchange to avoid inappropriate disclosures. In addition, I may use or disclose your health information in the following ways:

I may use or disclose your Protected Health Information to bill and collect payment for the services I provide to you. I may contact your insurance plan or third-party payer to confirm your coverage or to request prior approval for a planned treatment or service.

I may contact you by telephone or by mail to remind you of a healthcare appointment or to discuss payment or treatment issues. If you are not home when I telephone you, I may leave messages for you. If you want me to contact you in a certain way or at a certain location, please notify me in writing before we begin therapy.

There are some services that are provided for us by my business associates such as accountants, consultants (supervisors), and attorneys. Whenever we share information with our business associates, we have a written contract with them that requires that they safeguard the privacy of your Protected Health Information.

I may use and disclose Protected Health Information about you to a family member, other relative, close friend or any other person identified by you and with your permission only if they are involved in your care or responsible for payments related to your care. I may also use or disclose medical information about you to notify those persons of your location and general condition. If there is a family member, other relative, or close friend to whom you do not want me to disclose medical information about you, please notify me in writing.

## Uses or Disclosures That Are Required or Permitted by Law

I may use or disclose Protected Health Information without your consent or authorization in the following circumstances:

**Child Abuse:** If I have reasonable cause to believe that a child is deserted, neglected or abused, I must report this belief to the appropriate authorities, which may include the Kentucky Cabinet for Families and Children or its designated representative, the commonwealth attorney or the county attorney, or local law enforcement agency or the Kentucky state police. "

**Adult Domestic Abuse:** If I have reasonable cause to believe that an adult has suffered abuse, neglect; or exploitation, I must report this belief to the Kentucky Cabinet for Families and Children or Adult Protective Services.

**Health Oversight Activities:** The Kentucky Board of Social Work may subpoena records from me relevant to its disciplinary proceedings and investigations.

**Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information regarding treatment and records, I will not release information without your written authorization or that of your personal or legally-appointed representative unless there is a court order .

**Serious Threat to Health or Safety:** If you communicate to your therapist an actual threat of physical violence against a clearly identified or reasonably identifiable victim including yourself, or an actual threat of some specific violent act, the therapist has a duty to notify the victim and law enforcement authorities.

**Worker's Compensation:** If you file a claim for worker's compensation, you waive the psychotherapist-patient privilege and consent to disclosure of your health information reasonably related to your injury or disease to your employer, worker's compensation insurer, special fund, uninsured employers' fund, or the administrative law judge.

## Uses or Disclosures That Require Your Authorization

Uses and disclosures other than those discussed in this Notice will be made only with your written authorization. You may cancel your authorization at any time by notifying me in writing.

If you cancel an authorization it will not have any affect on information that we have already disclosed.

## Your Rights Regarding your Personal Health Information

The therapy record I create about you is my property. The information in the therapy record belongs to you. As such, you have the following rights:

**Right to Request Restrictions**

You have the right to ask me not to use or disclose your Protected Health Information for a particular reason related to treatment, payment or my business operations. This request must be made in writing. I do not have to agree to your request for reasons such as the limiting effect it has on my ability to provide treatment, services or obtain payment. If I agree to your request, I must keep the agreement, except in the case of a medical emergency. Either you or I can stop a restriction at any time.

**Right to Inspect and Copy Your Medical Information**
You have the right to ask to inspect and obtain a copy of your therapy record. You must submit your request in writing. I may charge a fee for the costs of copying and/or mailing your therapy record for you.

I may deny your request under certain limited circumstances. If your request is denied, you will be notified in writing and will be informed of your rights relating to requesting a review of my denial.

**Right to Request Amendments to Your Medical Information**
You have the right to request that I correct or amend your therapy record. If you believe that any information in your record is incorrect or that some important information is missing, you must submit your request in writing. I have the discretion of accepting or denying your request. If your request is denied, you will be notified in writing and will be informed of your rights relating to requesting a review of my denial.

**Right To An Accounting of Disclosures of Health Information**
You have the right to find out what disclosures of your therapy information have been made . The list of disclosures is called an accounting. The accounting may be for up to five (5) years prior to the date on which you request the accounting. The accounting will not include disclosures for treatment, payment, or healthcare operations or certain other exceptions. Requests for an accounting of disclosures must be submitted in writing.

**Right to Obtain a Copy of the Notice**
You have the right to ask for and receive a hardcopy of this notice and any revisions made to the notice at any time. In addition, the revised notice will be posted in a prominent location in my office and on my website on or after the effective date of revision.

**How to make a complaint**

Please notify me by phone or mail if you believe I have violated your privacy rights. In addition, you have the right to make a complaint to the United States Secretary of Health and Human Services. There is no risk involved if you file a complaint with me or the Secretary of Health and Human Services.

Complaints to the Secretary must: (l) be filed in writing, either on paper or electronically; (2) must include my name as the subject of the complaint and describe the acts or omissions believed to be in violation; and (3) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred. This time limit may be waived for good cause shown. Complaints to the Secretary of Health and Human Services may be filed only with respect to alleged violations occurring on or after April 14, 2003.

The Secretary of Health and Human Services has delegated to the Office of Civil Rights ("OCR") the authority to receive and investigate complaints as they may relate to a violation of this federal regulation. Complaints should be addressed to the OCR Regional Office that is assigned to the respective state in which the Community is located. Complaints may also be filed via e-mail at OCRComplaint@hhs.gov

Individuals may, but are not required to, use OCR's Health Information Privacy Complaint Form. To obtain a copy of this form, or for more information about the Privacy Rule or how to file a complaint with OCR, contact any OCR office or go to www.hhs.gov/ocr/hipaa/.

**Where o File Complaints Concerning Health Information Privacy**

**For complaints involving covered entities located in Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, or Tennessee:**

***Region IV*** Office of Civil Rights, U.S. Department of Health & Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW.,
Atlanta, Georgia 30303-8909.
Voice Phone (404) 562-7886.
FAX (404) 562-7881. TDD (404) 331-2867.

## Summary of Notice of Privacy Practices

The following information is a summary of the **Notice of Privacy Practices**, which is attached in full text. **THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

I am required by law to maintain the privacy of your personal health information including providing you with a copy of this notice. I must follow the terms of this notice. If this notice is changed in any material way, a revised notice will be available upon request. The revised notice will be posted in a prominent location in my office and on my website on or after the effective date of the revision.

I may use your medical information during the normal course of business for payment, treatment and health care operations. In addition, I may use or disclosure your information for any uses that are required or permitted by law. Other uses and disclosures will be made only with your written authorization. You may cancel an authorization at any time by notifying me in writing.

You have the following rights: **Right to a copy of my privacy notice; Right to request restrictions on uses and disclosures of your personal health information; Right to inspect and copy your medical information; Right to request an amendment to your medical information; and Right to an accounting of disclosures of your medical information.**

As indicated by my signature below I hereby acknowledge receipt and understanding of the ***Notice of Privacy Practices.***

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***Signature of Client/legal Representative*** ***Date***

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***Printed Name of Client/legal Representative***

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***Authority of Legal Representative***

***Signed Summary Notice of Privacy Practices to will be retained with the Services Agreement in my file. The Client is to retain the Notice of Privacy Practices.***