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## NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION (HIPPA)

This notice describes how mental health and medical information about you may be used and disclosed according to the Health Insurance Portability Act of 1996 (HIPPA).

### **USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:**

There are instances when I may use or disclose your Protected Health Information (PHI), however I cannot do so without your consent. These include treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- PHI refers to information about your health record that could identify you.
- TREATMENT is when I provide, coordinate, or manage your health care and other services related to your care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health provider.
- PAYMENT is when I obtain reimbursement for services provided. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- HEALTH CARE OPERATIONS are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

### **OTHER USES AND DISCLOSURES REQUIRING AUTHORIZATION:**

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. I will also need to obtain an authorization before releasing your Psychotherapy Notes, which are notes I have made about our conversation during a

private, group, joint, or family counseling session. These notes are kept separate from the rest of your medical record and are given a greater degree of protection than PHI.

You may revoke all such authorizations in writing at any time. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

### **USES AND DISCLOSURES WITHOUT AUTHORIZATION:**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **CHILD ABUSE:** If I know or have reasonable cause to suspect that a child has been abused or neglected, I must report the matter to the appropriate authorities as required by law.
- **ELDER ADULT OR DEPENDENT ABUSE:** If I suspect that an adult has been abused, neglected, or exploited and I have reasonable cause to suspect that the adult is either disabled or dependent, I must report the matter to the appropriate authorities as required by law.
- **HEALTH OVERSIGHT ACTIVITIES:** I may disclose PHI to the Maine Board of Examiners of Psychologists, or one of its representatives, as required for regulation, accreditation, licensure, or certification.
- **JUDICIAL AND ADMINISTRATIVE PROCEEDINGS:** If you are involved in a court proceeding, information about your diagnosis, treatment, and records is privileged under state law. I cannot release information without the written authorization of you, your legally appointed representative, or a court order.
- **SERIOUS THREAT TO HEALTH OR SAFETY:** If, in my reasonable professional judgment, I believe that you pose a direct threat of imminent harm to the health or safety of any individual, including yourself, I am legally required to disclose PHI to the appropriate persons.
- **WORKER'S COMPENSATION:** I may disclose PHI as authorized by and to the extent necessary to comply with the laws relating to worker's compensation or other similar programs that provide benefits for work-related injuries or illness without regard to fault.

### **PATIENT'S RIGHTS AND MENTAL HEALTH PROVIDER'S DUTIES:**

PATIENT'S RIGHTS:

- **RIGHT TO REQUEST RESTRICTIONS:** You have the right to request restrictions on certain uses and disclosures of your PHI. However, I am not required to agree to a restriction you request.
- **RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are seeing me. On your request, I will send your bills to another address.

- **RIGHT TO INSPECT AND COPY:** You have the right to inspect or obtain a copy (or both) of PHI in your Clinical Record for as long as the PHI is maintained in the record. This request must be made in writing. If I believe that it may be harmful for you to receive the records, I may deny the request. In those cases, you may request a summary and to have the records sent to another provider or attorney.
- **RIGHT TO AMEND:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **RIGHT TO AN ACCOUNTING:** You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

**MENTAL HEALTH PROVIDER’S DUTIES:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI (this form).
- I reserve the right to change the privacy policies and practices described in this notice. If policies and procedures are revised, you will be notified in writing by standard mail. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

**COMPLAINTS:**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Office for Civil Rights, which can be reached at (617) 565-1340. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

**EFFECTIVE DATE, RESTRICTIONS, AND CHANGES TO PRIVACY POLICY:**

This notice will go into effect on May 1, 2013.

Your signature below indicates that you have read the information in this document and received a copy of this information for your records.

\_\_\_\_\_  
Client Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client or Parent/Guardian Signature

\_\_\_\_\_  
Elyse Corbett, Ph.D.

\_\_\_\_\_  
Date