TAMMY POWELL LLC
NOTICE OF PRIVACY PRACTICES

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable laws. It also describes your rights regarding how you may gain access to and control of your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will disclose only the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities, including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. We may use PHI to remind you of appointments. We may use PHI to provide information about treatment alternatives or other health-related benefits and services. For training or teaching purposes, PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect, or mandatory government agency audits or investigations, such as the state counselor licensing board or the health department.
- Required by court order.
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person of the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or personals reasonably able to prevent or lessen the threat, including the target of the threat.
- For emergency care. PHI may disclosed with payers and other providers of treatment and health services if the purpose of the exchange is to facilitate continuity of care for a patient or for the emergency treatment of an individual.
- For persons involuntary committed to a board. Community mental health services providers may exchange psychiatric records and certain other information with the board of alcohol, drug addiction, and mental health services and other services providers in order to provide services to a person involuntarily committed to a board. Release of records under this division shall be limited to medication history, physical health status and history, financial status, summary of course of treatment, summary of treatment needs, and discharge summary, if any.
- For estate purposes. PHI may be disclosed to the executor or the administrator of an estate of a deceased patient when the information is necessary to administer the estate.
- For other reasons as written out in the Ohio Revised Code 5122.31

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which you may revoke.

Verbal Permission. We may use or disclose your information to family members who are directly involved in your treatment with your verbal permission.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to TAMMY POWELL LLC, 9876 Maineville Rd., Loveland, OH 45140 or 3092 Madison Ave., Cincinnati, OH 45209.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use of disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with your about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to TAMMY POWELL, LLC, 9876 Maineville Rd., Loveland, OH 45140 or 3092 Madison Ave., Cincinnati, OH 45209, or with the Ohio Counselor, Social Worker, and Marriage & Family Therapist Board at 77 South High St., 24th Floor, Columbus, OH 43215. **We will not retaliate against you for filing a complaint.**

TAMMY POWELL LLC
NOTICE OF PRIVACY PRACTICES
Receipt and Acknowledgement of Notice

Client Name: _____ **D.O.B.**: _____

I hereby acknowledge that I have received and been given an opportunity to read a copy of the Privacy Practices for TAMMY POWELL LLC. I understand I may contact TAMMY POWELL LLC if I have any questions regarding this notice of privacy practices.

_____
Signature of Client Date

_____
Signature of Parent, Guardian, or Personal Representative Date

_____
(*If you are signing as a personal representative of an individual, please describe your legal authority to act on behalf of this individual (e.g., power of attorney, healthcare surrogate, etc.).)

_____ Initial for client refusal of acknowledgement or agreement of receipt

_____
Signature of Provider Date