

HIPAA NOTICE OF PRIVACY AND HEALTH INFORMATION PRACTICES

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

This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This Notice is effective January 17, 2008, and applies to all Protected Health Information as defined by Federal Regulations.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals;
- a source of data for medical research;
- a source of information for public health officials charged with improving the health of the State and/or Nation;
- a source for public safety;
- a source of data for facility planning and marketing and
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

Online Therapy Services may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes, as long as you consent to receive evaluation or treatment services from the clinic. To help clarify these terms, here are some definitions:

“Treatment, Payment, and Health Care Operations” Treatment is when a therapist provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when a therapist consults with a clinical faculty member who has expertise in a clinical problem. Payment is when Online Therapy Services obtains reimbursement for your healthcare. An example of payment is when Online Therapy Services discloses your PHI to a health agency such as the Department of Social Services so Online Therapy Services may obtain reimbursement for your health. *Health Care Operations* are activities that relate to the performance and operation of Online Therapy Services. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination, conducting training and educational programs or accreditation activities.

“Use” applies only to activities within Online Therapy Services such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

“Disclosure” applies to activities outside of Online Therapy Services, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

Online Therapy Services may use or disclose PHI for purposes outside treatment, payment, or healthcare operations when your appropriate authorization is obtained. An *“authorization”* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Online Therapy Services is asked for information for purposes outside of treatment, payment or healthcare operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that Online Therapy Services has relied on that authorization for your ongoing treatment and/or payment of services.

Uses and Disclosures with Neither Consent nor Authorization

Online Therapy Services may use or disclose PHI without your consent or authorization in the following circumstances:

- *Abuse* – If we have reason to believe that a minor child, elderly person or disabled person has been abused, abandoned, or neglected, Online Therapy Services must report this concern or observations related to these conditions or circumstances to the appropriate authorities.
- *Health Oversight Activities* – If the Virginia Board of Psychology is investigating a clinician that you have filed a formal complaint against, Online Therapy Services may be required to disclose protected health information regarding your case.
- *Judicial and Administrative Proceedings as Required* – If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof, we may be compelled to provide the information. Although courts have recognized a therapist-patient privilege, there may be circumstances in which a court would order Online Therapy Services to disclose personal health or treatment information. Online Therapy Services will not release information without your written authorization, or that of your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a

- third party (e.g. Law enforcement agency or Social Security) or where the evaluation is court ordered. •
- *Serious Threat to Health or Safety* – If you communicate to Online Therapy Services personnel an explicit threat of imminent serious physical harm or death to identifiable victim(s), and we believe you may act on the threat, we have a legal duty to take the appropriate measures to prevent harm to that person(s) including disclosing information to the police and warning the victim. If we have reason to believe that you present a serious risk of physical harm or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.
 - *Worker's Compensation* – Online Therapy Services may disclose protected health information regarding you as authorized by, and to the extent necessary, to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
 - *National Security*- We may be required to disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may be required to disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may be required to disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances. *Research*- Under certain limited circumstances; we may use and disclose health information for research purposes. All research projects, however, required prior approval by the Department of Psychology Human Subjects Committee and an institutional review board.

Your Health Information Rights:

Although your health record is the physical property of the Online Therapy Services, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

Online Therapy Services is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice

Online Therapy Services

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- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact Online Therapy Services at Phone: (833) 835-7792 Fax (866) 299-2424.

If you believe your privacy rights have been violated, you have the right to complain to us at the above address or to the Secretary of Health and Human Services. We support your right to the privacy of your health information. You will not be penalized, retaliated against, or otherwise treated differently for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices from Online Therapy Services

By signing this form, I am providing consent to the use of electronic and verbal signatures to establish my identity and sign electronic documents and forms associated with the provision of care by Online Therapy Services. I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature or verbal approval has the full force and effect of a signature affixed by hand to a paper document.

By checking this box, I accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my care.

Patient/Parent/Guardian Signature (Please type full name) _____

Printed Name: _____

Date: _____