Cynthia M. Dowdy, Ph.D.
Licensed Professional Counselor
4601 Lake Boone Trail, Suite 2C
Raleigh, North Carolina 27607
(919) 349-2146

Notice of Privacy Practices

This notice was created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Effective Date of this Notice: April 14, 2003.

This notice describes how health information about you as a client of this practice may be used and disclosed and how you can get access to your health information.

Please review it carefully.

My practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting business, I will create records regarding your treatment and the services provided to you.

I reserve the right to revise or amend this Notice of Privacy Practices, and any changes will be effective for all your records created since April 14, 2003 and for any records created in the future. I will post in the office in a visible location my current Notice, and you can request a copy of my current Notice at any time.

I. **I may use and disclose your health information (PHI) in the following ways for treatment, payment, and health care operations.**

1. **Treatment.** I may use or disclose your PHI for purposes of coordinating or managing your health care and other services related to your health care. Examples of coordinated treatment include consulting with another health care provider, such as a physician, psychiatrist, nutrition specialist, or another therapist. In these situations, where you are not receiving direct treatment with another health care provider, I will make every effort to avoid revealing your identity.

   Personality and other assessment results may be coordinated with outside testing agency.

   I may also disclose your PHI to others who may assist in your care, such as your spouse, children, parents, or personal representative **unless otherwise specified.**

2. **Payment.** I may use and disclose your PHI in order to bill and collect payment for the services you receive from me. For example, I may contact your health

insurer to certify what mental health benefits you are eligible for and what your coverage plan is, and I may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, I may use your PHI to bill you directly for services and items.

3. **Appointment Reminders.** I may use or disclose your PHI to contact you and remind you of an appointment. If I receive your voice mail, I will leave my name, number, and appointment information, but will not reveal what the appointment concerns.

4. **Release of Information to Family/Friends.** I may disclose information about you to persons who are involved in your care or payment for your care, such as family members, relatives, or close personal friends **unless otherwise specified.** Any such disclosure will be limited to information directly related to the person's involvement in your care.

   I will contact person(s) you listed as your emergency contact and/or who answer your home phone number. If you are available, I will provide you an opportunity to object before disclosing any such information. If you are unavailable, for example, because you are incapacitated or because of some other emergency circumstance, I will use my professional judgment to determine what is in your best interest regarding any such disclosure.

5. **Health Care Operations** are activities that relate to the performance and operation of my practice. I may share health information about you with business associates who are performing services on our behalf. For example, I may contract with a company to service my computer, do my billing, and provide answering and check-in service. My business associates are obligated to safeguard your health information. I will share with my business associates only the minimum amount of personal health information necessary for them to assist.

6. **Disclosures Required by Law.** My practice will use and disclose your PHI when we are required to do so by federal, state or local law.

   I will obtain authorization (written permission) from you for any release of information *beyond* the general consent for the above listed specific disclosures. You may revoke all such authorizations at any time, provided each revocation is in writing.

II. Use and disclosure of your PHI in certain special circumstances

The following categories describe unique situations in which I may use or disclose your

health information with *neither consent nor authorization*.

1. **Child Abuse.** If you give me information which leads me to suspect child abuse, neglect, or death due to maltreatment, I must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, I must do so.

2. **Adult and Domestic Abuse.** If information you provide me gives me reasonable cause to believe that a disabled adult is in need of protective services, I must report this to the Director of Social Services.

3. **Health Oversight Activities.** I may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights and the health care system in general.

4. **Judicial or Administrative Proceedings.** If you are involved in a court proceeding, and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

5. **Serious Threat to Health or Safety.** I may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, I will only make disclosures to a person or organization able to help prevent the threat.

6. **Workers' Compensation.** I may release your PHI for workers' compensation and similar programs when required by law.

7. **Minors.** If you are an unemancipated minor under North Carolina law, there may be circumstances in which I disclose health information about you to a parent, guardian, or other person acting *in loco parenti*s, in accordance with legal and ethical responsibilities.

8. **Notification.** I may notify a family member or other person you have noted as emergency contact of your general condition. If you are available, I will provide you an opportunity to object before disclosing any such information. If you are unavailable, for example, because you are incapacitated, I cannot reach you at your home or work number for several days, or because of some other

emergency circumstance, I will use my professional judgment to determine what is in your best interest regarding any such disclosure.

9. **Parents.** If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, I may disclose health information about your child to you under certain circumstances. For example, if I am legally required to obtain your consent as your child's personal representative in order for your child to receive care from me, I may disclose health information about your child to you. In some circumstances, I may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, I may not disclose health information about your child to you without your child's written authorization.

10. **Personal Representative.** If you are an adult or emancipated minor, I may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

III. Psychotherapy Notes

For every client that participates in therapy, I create three files: a billing file, a general medical record file, and a psychotherapy note file. These files are stored in a locked filing cabinet and will be kept for six years from the beginning date of therapy. Another appointed licensed health care professional or my licensing board will be in charge of handling the files if I should become incapacitated.

I will keep separate notes during the course of your therapy sessions about our conversations. These notes are kept apart from the rest of your medical records and are not available to anyone. You cannot be required to authorize the release of your psychotherapy notes to obtain health-insurance benefits for your treatment, or enroll in a health plan. Psychotherapy notes are also not among the records that you may request to review or copy.

Your medical records include basic information, such as your medication treatment record, counseling session start and stop times, the types and frequencies of treatment you receive, and your test results. They also include a summary of your diagnosis, condition, treatment plan symptoms, prognosis, or treatment progress. Medical records may be disclosed by a therapist only after you have given written authorization to do so. (Limited exceptions exist, for example, in order for your therapist to prevent harm to yourself or others, and to report child abuse/neglect).

IV. Your Rights Regarding Your Personal Health Information (PHI)

1. **Confidential Communications.** You have the right to request that I communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that I contact you at home, rather than work or your bills be sent to another address. In order to request a type of confidential communication, you will need to make a written request specifying the requested method of contact, or the location where you wish to be contacted. I will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in my use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. I am not required to agree to your request; however, if we do agree, I am bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in my use or disclosure of your PHI, you must make your request in writing and describe in a clear and concise fashion a) the information you wish restricted; b) whether you are requesting to limit my practice's use, disclosure or both; and c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but **not** including psychotherapy notes. You must submit your request in writing in order to inspect and/or obtain a copy of your PHI. I may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. I may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of my denial by another licensed health care professional chosen by me.

4. **Amendment.** You may ask me to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for my practice. To request an amendment, your request must be made in writing and submitted to me. You must provide me with a reason that supports your request for amendment. I will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, I may deny your request if you ask me to amend information that is in my opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI which you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All my clients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain **non-routine** disclosures my practice has made of your PHI for non-treatment

or operations purposes. Use of your PHI as part of the routine client care is not required to be documented. For example, routine sharing of information with billing services, using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to me. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but I may charge you for additional lists within the same 12-month period. I will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper copy of This Notice.** You are entitled to receive a paper copy of this notice of privacy practices. You may ask me to give you a copy of this notice at any time.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** I will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide me regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, I am required to retain records of your care.

If you have any questions regarding this notice of health information privacy policies, please contact me at 919-349-2146.

Cynthia M. Dowdy, Ph.D.
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Client Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Cynthia M. Dowdy to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The Notice of Privacy Practices provided by Cynthia M. Dowdy gives a more complete description of such uses and disclosures.

I have the right to review and receive the Notice of Privacy Practices prior to signing this consent. Cynthia M. Dowdy reserves the right to revise her Notice of Privacy Practices at any time. A revised Notice of Privacy Practices can be obtained by forwarding a written request to:

Cynthia M. Dowdy, Ph.D.
4601 Lake Boone Trail, Suite 2C
Raleigh, NC 27607

With this consent, Cynthia M. Dowdy may mail to my home or other alternative location any items that assist the practice in carrying out TPO. I am aware that this practice is not required to agree to my restrictions. However, if it does agree to my restrictions, it is bound by the agreement.

By signing this form, I am consenting to Cynthia M. Dowdy's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cynthia M. Dowdy may decline to provide treatment to me.

____ __________
Signature of Client or Legal Guardian Date

____
Print Name of Client or Legal Guardian

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ____________________________, have received a copy of Cynthia M. Dowdy's Notice of Privacy Practices.

____ __________
Signature of Client Date