Erik R. Jackson, Ph.D., Clinical Psychologist
WA State License No. 3518
818 Twelfth Avenue
Seattle, WA 98122
206.329.5255 ext. 311

Policies & Practices to Protect the Privacy of Your Health Care Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information.

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

I may use or disclose you Protected Health Information (PHI) for treatment, payment, and for the purpose of health care operations with the consent you have provided by signing my **Consent for Treatment** form, or in certain cases, by requesting that you sign a specific authorization allowing me to disclose health care information about you.

- "PHI" refers to information in your treatment record that identifies you.

- "Treatment" is when I provide your health care or manage it, for example by seeking a consultation with another health care professional as a way of better serving your needs.

- "Payment" is when I attempt to obtain authorization or reimbursement for services, generally from the information you provide regarding your insurance or managed care coverage.

- "Health Care Operations" are activities that relate to running my practice, which can include an outside assessment of my compliance with regulations, audits, administrative services, case management, and other business-related matters.

- "Use" applies to activities within my office that help to mange the services I provide.

- "Disclosure" applies to activities outside my office, including providing access or releasing information to other individuals or organizations.

Uses and Disclosures Requiring Authorization

By signing a Disclosure Form, you allow me to use or disclose information about you for purposes of treatment, payment, and health care operations. This provides specific permission above and beyond that which you have given by signing my **Consent for Treatment** form. I will request that you sign a Disclosure Form if am asked to release information for purposes of your treatment elsewhere, payment or health care operations. I will also need you to sign a Disclosure Form if you request that I release your progress notes. These are notes that I have made for my use to assist me in providing you the best care possible. These notes contain very sensitive material and are not written with the intention of being released, so they are given a higher degree of protection than PHI.

You may revoke all authorizations at any time by written request. However, you may not

revoke an authorization if I have already taken action on it based on your prior signature. Further, if the authorization was obtained as a condition of acquiring or using insurance benefits, your insurance company has a legal right to receive information to contest a claim.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization:

- If I have reasonable cause to believe that a child has been abused or neglected, I am required to report my suspicion to law enforcement and to the Department of Social and Health Services.

- If I have reasonable cause to believe that an elderly person or other vulnerable adult has been abused, abandoned, exploited or neglected, I am required to report my suspicion to the Department of Social and Health Services. If I have reason to suspect sexual or physical assault, I must additionally inform law enforcement.

- If the Washington Examining Board of Psychology subpoenas me as part of an investigation, I am required to comply and may be asked to disclose your PHI.

- If you are involved in a legal proceeding and a request is made for information regarding the services I have provided. Your PHI is privileged under State law; however, I must release your PHI if I am presented with a signed Disclosure Form from you or your representative, if I receive a properly executed subpoena and you have failed to inform me that you are contesting the subpoena, or if I am ordered to release your PHI by a court or for a third party.

- If I have reasonable cause to believe that you are a threat to your own or another person's health or safety, I am required to report this suspicion in order to protect your well-being or that of another person.

- If you file a Worker's Compensation claim, I must make available any PHI in my possession that is relevant to your particular injury. Relevance is determined by the Department of Labor and Industries. This department, along with your employer and any personal representative can request your PHI.

- As a result of state regulations adopted by the Washington State Department of Health, I am required to report myself of another healthcare provider in the event of a final determination of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if I have actual knowledge of unprofessional conduct by another licensed provider. Note: If you yourself are a healthcare provider, and I believe that your behavior is a clear and present danger to your patients or clients, I am also required to report you.

Patient Rights

- You have the right to request restrictions on certain uses and disclosures of your PHI; however, I am required to agree to your requested restrictions.

- PHI that you request will normally be provided through your common mailing address and phone numbers. You have the right to provide a written request to receive communication of your PHI at an alternate address or phone.

- You have the right to view or receive a copy of your file including PHI and progress notes; however, I may deny you access under certain circumstances. You can appeal my denial if you so request. As a general rule, I will discourage your review of progress notes as they contain very sensitive material and they are written as an aide to me in providing for your care.

- You have the right to request an amendment of your PHI; however, I may deny your request. Upon your request, I will discuss the process of executing this amendment.

- You have the right to receive an accounting of disclosures made to your PHI for which you have neither provided consent nor authorization. Upon your request, I will discuss the process for obtaining this accounting.

- You have the right to obtain a replacement copy of this notice upon request.

- You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- You have the right to be notified if: (a) there is a breach (use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychological Duties

- I am required by law to maintain the privacy of your PHI and to provide this notice outlining my policy regarding the privacy of your PHI.

- I may from time to time change my privacy policies and will notify you in writing at your next psychotherapy appointment following that change. Unless I notify you of a change, my policies will remain as written in this document.

Complaints

If you believe that I have violated your privacy rights or you disagree with a decision that I make regarding access to your PHI, you may contact the Examining Board of Psychology at 360.236.4910 or by writing them at P.O. Box 47869, Olympia, Washington 98504-7869. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Effective Date

These privacy policies are effective as of September 13, 2013.

Client Acknowledgement

If you have questions about anything you've read here, please discuss them with me prior to signing this form. Your signature below indicates that you have read and received a copy of these policies.

_____	_____
Client #1 Signature	Date
_____	_____
Client #2 Signature (for couples counseling)	Date
_____	_____
Erik R. Jackson, Ph.D.	Date

Please remove this page and return as a permanent part of file:

Client Acknowledgement

If you have questions about anything you've read here, please discuss them with me prior to signing this form. Your signature below indicates that you have read and received a copy of the as summarized by the document entitled “Policies and Practices to Protect the Privacy of Your Health Care Information”, which provided you information about the use and disclosure of your private health information.

_____	_____
Client #1 Signature	Date
_____	_____
Client #2 Signature (for couples counseling)	Date
_____	_____
Erik R. Jackson, Ph.D.	Date