THE CONATIVE GROUP PLLC
THINKING, FEELING, GROWING

TEXAS NOTICE FORM

Notice of Clinical Psychologist's Policies and Practices
To Protect the Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used anddisclosed and how you can get access to this information. Please review it carefully. Note: "I"refers to the therapist, and "you" refers to the therapy patient.

I. Uses and Disclosure for Treatment, Payment, and Healthcare Operations

As a provider of psychological services, I may use or disclose your Protected Health Information (PHI) for treatment, payment, and healthcare operations purposes with your consent. To helpclarify these terms, here are some definitions:

a. Protected Health Information (PHI) – information in your health record that could identify you

b. Use – applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you

c. Disclosure – applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties

d. Treatment – when I provide, coordinate, or manage your healthcare and other services related to your healthcare (example: when I consult with another healthcare provider, such as your family physician or another therapist)

e. Payment – when I obtain reimbursement from your healthcare (example: when I disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility for coverage)

f. Healthcare operations – when I need to conduct activities relating to the performance and operation of my practice (examples: when I conduct quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination)

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained.

a. Authorization – written permission, above and beyond the general consent, that permits

only specific disclosures

When a third-party requests information about your treatment from me for purposes outside oftreatment, payment, and healthcare operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing yourpsychotherapy notes.

b. Psychotherapy notes – notes I have made about a conversation you and I have had duringa private, joint, or family counseling session which I have kept separate from the rest ofyour medical record are given a greater degree of protection than PHI

You may revoke all such authorizations (of PHI and psychotherapy notes) at any time, providedeach revocation is in writing. You may not revoke an authorization:

- To the extent that I have relied on that authorization, or
- If the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to content the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

a. Child abuse – If I have cause to believe that a child has been or may be physically abused, neglected, or sexually abused, I must make a report of such within 48 hours to:
   i. The Texas Department of Protective and Regulatory Services,
   ii. The Texas Youth Commission, or
   iii. Any local or state law enforcement agency.

b. Adult or domestic abuse – If I have cause to believe that an elderly or disabled person isin a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.

c. Health oversight – If a complaint is filed against me with the State Board of Examiners of Psychologists, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

d. Judicial or administrative proceedings – If you are involved in a court proceeding, and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without written authorization from you, your personal or legally appointed representative, 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 informedin advance if this is the case.)

e. Serious threat to health or safety – If it is determined that there is a probability of imminent physical injury by you to yourself or others, or if there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

f. Worker's compensation – If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Clinical Psychologist's Duties

You have the following **patient's rights**:

a. Right to request restrictions – right to request restrictions on certain uses and disclosures of protected health information about you (Note: I am not required to agree to a restriction that you request.)

b. Right to request communications – right to request and receive confidential communications of PHI by alternative means and at alternative locations (example: You may not want a family member to know that you are being seen at this office, so uponyour request, I will send your bills to another address.)

c. Right to inspect and copy – right to inspect and/or obtain a copy of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for aslong as the PHI is maintained in the record (Note: Your access to PHI may be denied undercertain circumstances, but in some cases, you may have this decision reviewed. On your request, I can discuss with you the details of the request and denial process.)

d. Right to amend – right to request an amendment of PHI for as long as the PHI is maintained in the record (Note: Your request may be denied. On your request, I can discuss with you the details of the amendment process.)

e. Right to an accounting – right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Texas Notice Form) (Note: On your request, I can discuss with you the details of the accounting process.)

f. Right to a paper copy – right to obtain a paper cop of the notice from me upon request, even if you have agreed to receive the notice electronically

I have the following **Clinical Psychologist's duties:**

g. I am required by law to maintain the privacy of PHI and to provide you with a notice ofmy legal duties and privacy practices with respect to PHI.

h. I reserve the right to change the privacy policies and practices described in this Texas Notice Form. Unless you are notified of such changes, however, I am required to abide by the terms currently in effect.

i. If I revise my policies and procedures, I will post changes in my office and notify my patients by providing them with an updated copy of my policies and procedures.

V. Complaints

If you believe that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact me at the above phone number or address.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. On your request, I can provide you with the appropriate address.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1, 2018.

- I reserve the right to change the terms of this Texas Notice Form and to make the new notice provisions effective for all PHI that I maintain.
- I will provide you with a revised notice by posting changes in my office.

Your signature below acknowledges that you have read the above information, have asked for clarification about anything that you do not understand, and have received a copy of this information.

_____

Name of child patient

_____

Name of parent/guardian

Relationship SELECT ONE:____

_____

Signature of patient **Date**