Notice of Privacy Practices

HAWKSBILL MENTAL HEALTH COUNSELING

229 Washington Street, Suite 305

Saratoga Springs, NY 12866

518-316-4890

EFFECTIVE DATE OF THIS NOTICE This notice went into effect on November 1, 2024

NOTICE OF PRIVACY PRACTICES OF HAWKSBILL MENTAL HEALTH COUNSELING (HMHC)

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

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice of Privacy Practices **("Notice")** for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new Notice effective for all protected health information that we maintain at that time. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice or information pertaining to a specific state law may be obtained by mailing a request to the address sent forth at the end of this Notice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Uses and Disclosures That May Be Made Without Your Consent

Uses and Disclosures for Treatment: HMHC may use and disclose your protected health information as necessary for your treatment. We may disclose your protected health information to other health care providers treating you and to other personnel involved in your overall care.

Uses and Disclosures for Payment: HMHC may use and disclose your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your treatment and services to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We may use and disclose your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, and licensing. For instance, we may use and disclose your protected health information for purposes of improving the clinical treatment and patient care.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accounting, and legal services. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: HMHC may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate reasonable requests by you, to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to the address set forth at the end of this Notice.

Other Uses and Disclosures: HMHC is permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- any purpose required by law;
- public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations;
- if we suspect child abuse or neglect;

- if we believe you to be a victim of abuse, neglect, or domestic violence;
- to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- in response to a court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary, to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military we may also release your protected health information for national security or intelligence activities; and
- to workers' compensation agencies for workers' compensation benefit determination.

B. Uses and Disclosures That May Be Made Either with Your Authorization or the Opportunity to Object

Individuals Involved in Your Care: Unless you object, HMHC may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with involved individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

C. Uses and Disclosures Based Upon Your Written Authorization

Marketing: HMHC must obtain your written authorization to use and disclose your protected health information for most marketing purposes.

Sale of Protected Health Information: We must obtain your written authorization for any disclosure of your protected health information which constitutes a sale of protected health information.

Other Uses: Other uses and disclosures of your protected health information, not described above, will be made only with your written authorization. You may revoke your authorization, at any time, in writing, except to the extent that we have acted in reliance on the authorization.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to Your Protected Health Information: You have the right to copy and/or inspect the protected health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative and sent to the address set forth at the end of this Notice. If you request a copy of your protected health information you may be charged a nominal fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your legal representative and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information. Requests must be made in writing and signed by you or your legal representative. The first accounting in any 12-month period is free. You will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate. However, we must agree not to disclose your protected health information to your health plan if the disclosure is for payment or health care operations and relates to a health care item or service which you paid for in full out of pocket. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the address set forth at the end of this Notice.

Receive Confidential Communications from Us by Alternative Means or at Alternative Locations: You have the right to request that we communicate with you in a certain way or at a certain location. Your request must be in writing and

specify how and where you would like to be contacted. We will accommodate all reasonable requests.

Paper Copy: You have the right to obtain a paper copy of this Notice from us.

Breaches of Unsecured Protected Health Information: You have the right to be notified if you are affected by a breach of unsecured protected health information.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with Hawksbill Mental Health Counseling, 229 Washington Street, Suite 106, Saratoga Springs, New York 12866. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact Hawksbill Mental Health Counseling, 229 Washington Street, Suite 106, Saratoga Springs, New York 12866.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client Signature Date

_____

Client Printed Name

_____ _____

(Legal Guardian Signature if client is a minor) Date

_____

Legal Guardian Printed Name