



KARA SHAUGHNESSY, MSW, LCSW

5151 MATTIS RD., STE. B, ST. LOUIS, MO 63128

P: 314-275-0617 | F: 314-328-5489

KARA@EMPOWEREDLIFESTL.ORG | WWW.EMPOWEREDSTL.ORG

Notice of Privacy Practices and Use of Health Information

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

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements (including the HIPAA, the HIPAA Privacy and Security Rules, and the NASW Code of Ethics). This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

1. Make sure that protected health information (“PHI”) that identifies you is kept private.
2. Give you this notice of my legal duties and privacy practices with respect to health information.
3. Follow the terms of the notice that is currently in effect.
4. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment, Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client’s personal health information without the patient’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations. I may also disclose your protected health information for the

treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION - Your written authorization may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization.

1. *Psychotherapy Notes*. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
 - a. For my use in treating you.
 - b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
 - c. For my use in defending myself in legal proceedings instituted by you.
 - d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
 - e. Required by law and the use or disclosure is limited to the requirements of such law.
 - f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
 - g. Required by a coroner who is performing duties authorized by law.
 - h. Required to help avert a serious threat to the health and safety of others.
2. *Marketing Purposes*. As a psychotherapist, I will not use or disclose your PHI for marketing purposes, including subsidized treatment communications.
3. *Sale of PHI*. As a psychotherapist, I will not sell your PHI in the regular course of my business.

4. Other uses and disclosures not described in this Notice of Privacy Practices.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law;
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse or neglect;
3. For judicial and administrative proceedings, including responding to a subpoena, court or administrative order, although my preference is to obtain an Authorization from you before doing so;
4. For deceased patients, as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin;
5. In a medical emergency situation only in order to prevent serious harm, and staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency;
6. To close family members or friends directly involved in your treatment, based on your consent or as necessary to prevent serious harm;
7. For health oversight activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control;
8. Law enforcement purposes as required by law, in compliance with a subpoena (with your written consent), court or administrative order, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises;
9. Specialized government functions, including from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm

10. Public health activities for the purpose of controlling disease, injury, disability or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
11. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
12. Public safety, if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
13. Research and disclosure of PHI will only be considered after a special approval process or with your authorization.
14. Fundraising communications may be sent to you at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.
15. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI. To exercise any of these rights, please submit your request in writing to our office at Empowered Life Counseling LLC, 5151 Mattis Rd., Ste. B, St. Louis, MO 63128.

1. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care. To request restrictions, you must make your request in writing, and tell me: a) what information you want to limit; b) whether you want to limit my use, disclosure or both; and c) to whom you want the limits to apply.
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. **The Right to Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests. To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
4. **The Right to See and Get Copies of Your PHI.** Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. **The Right to Get a List of the Disclosures I Have Made.** You generally have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.
8. **The Right to Receive Notification of a Breach.** I am required to notify you if I discover a breach of your unsecured PHI, according to requirements under federal law.
9. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, please contact me. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint.

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on November 14, 2021.

For more information about your healthcare privacy rights:
<<https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>>

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.

We have discussed these policies and you understand that you may ask questions about them at any time in the future.

You consent to accept these policies as a condition of receiving mental health services.