Jen Hutchings, Ph.D, LMFT
16 North Monroe
Rockford, MI 49341
248-761-HOPE

Notice of Privacy Practices

Your confidentiality is very important to me.

This notice, required by law, describes how health information about you may be used and disclosed. You have likely received many such notices from banks, pharmacies, medical doctors, an insurance companies. Likewise, this notice stems directly from the passing of **HIPAA (Health Insurance Portability and Accountability Act of 1996)** into law.

Uses and Disclosures of Your Health Information

The purpose of this notice is to let you know how and to whom your private health information **(PHI)** can be disclosed. PHI is any information created by me in the course of your treatment that can identify you.
HIPAA allows for the disclosure of you PHI ***without your consent*** for the following reasons:

- to coordinate with other professionals
- to bill and collect payment for my services
- to leave message on your answering machine
- to comply with health oversight agencies (i.e. insurance co audits)

(However, because I believe so strongly in guarding the confidentiality of our work, along with the ethical guideline of my profession and state law, I will continue my usual policy of attempting to secure your permission for any disclosure except for the reasons stated below as required by law—see next page)

State of Michigan law requires that I disclose you PHI ***without your consent*** if:

- you are a danger to yourself or others
- you are unable to meet your basic physical needs
- you tell me of a serious and imminent threat of violence by you against another
- I have a reasonable suspicion of child abuse or neglect on your part

Client Rights

HIPAA also requires that I clearly outline your rights regarding your PHI.

- to see and/or get copies of your PHI within 30 days of your written request
- to limit the use and disclosure of your PHI *(see next page)*
- to request that I confidentially communicate with you in a certain way
- to get a list of disclosures of your PHI that I have made
- to ask me to update or modify your PHI if you believe your record is incorrect
- to request of copy of the notice at any time

Ask me about any of these rights and I will inform you of the outlined HIPAA procedures to exercise these right. This detailed information will also explain the possible denial of your requests and the course of action that you can take at that time. Please feel free to talk with me about specific questions or concerns.

Questions and Complaints

HIPAA requires that you receive this address if you believe that I have violated your privacy rights:

Secretary of the Dept of Health and Human Services
200 Independence Ave SW, Washington DC 20201

Receipt and Acknowledgement

I acknowledge receipt of Dr. Hutchings' Notice of Privacy Practices (HIPAA).

Client Name (Printed): _____ Client Signature:_____ Date: _____

Witness Name: Jen Hutchings, Ph.D Witness Signature: _____ Date: _____

Restrict Disclosure

I exercise my HIPAA right to restrict disclosure of my PHI by Dr. Hutchings. I understand that Dr. Hutchings will attempt to secure my permission for any specific disclosures except those she is legally required to make (see above).

Client Name (Printed): _____ Client Signature: _____ Date: _____