



Frank Gutierrez, LCPC
4801 W. Peterson Ave.
Chicago, IL 60646

NOTICE OF POLICIES AND PRACTICES
TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, and in accordance with the NASW Code of Ethics, this notice describes how health information about you may be used and disclosed and how you can access this information. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

I. Policies Regarding the Use and Disclosure of Your Health Information

With Authorization. We are committed to maintaining the privacy and confidentiality of our clients' health information. Information about you and/or your child, and the care provided will generally be used or disclosed, with your written authorization, only for purposes of:

- Providing, coordinating, or managing your health care treatment and related services (this includes consultation with clinical supervisors or other treatment team members);
- Payment-related activities. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of information necessary for purposes of collection.
- General operation of the practice, including quality assessment activities, employee review activities, licensing, to remind you of client appointments, and conducting or arranging for other business activities. For example, we may share your health information with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your information.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (e.g., the Professional Counseling licensing board or the health department);
- Required by Court Order;
- 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.

With Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

All Other Disclosures: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. We will also need to obtain an authorization

before releasing your Psychotherapy Notes. These are notes our therapists may have made about conversations during a counseling session, which they have kept separate from the rest of your record. These notes are given a greater degree of protection than other protected health information.

II. Patient's Rights

- You have the right to request restrictions on certain uses and disclosures of protected health information. We are not required to agree to requested restrictions, but will make every effort to do so, except in case of emergency as described above.
- You may revoke any authorizations to release information at any time, provided each revocation is in writing and that we have not already acted on the previous authorization. If the authorization was a condition of obtaining insurance coverage, the law provides insurers the right to contest the claim under the policy.
- You have the right to request that we communicate with you by alternative means (e.g., e-mail) and at alternative locations (e.g., at home rather than at work).
- You have the right to inspect or obtain a copy (or both) of your record for as long as the information is maintained in the record. Your right to inspect and copy information will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. On your request, we will discuss with you the details of the request for access process. We may charge a reasonable, cost-based fee for copies.
- You have the right to request an amendment of the record for as long as the information is maintained in the record, although we are not required to agree to the amendment. On your request, we will discuss with you the details of the amendment process.
- You generally have the right to receive an accounting of any disclosures of your record. On your request, we will discuss with you the details of the accounting process. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

III. Our Responsibilities

- We are required by law to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices with respect to this information.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we will abide by the terms currently in effect.
- If we revise these policies and procedures, we will give you or mail you a copy of the revised notice.

IV. Complaints

If you believe your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact Richard N. Goodman at 847-650-1995 or you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

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

This notice will go into effect on March 31, 2013.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all records that I maintain. We will provide you copies of any revised notice.

Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Frank Gutierrez, LCPC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Frank Gutierrez at 847-650-1995

Signature of Client *Date*

*Signature or Parent, Guardian or Personal Representative ** *Date*

** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

Client Refuses to Acknowledge Receipt:

Signature of Staff Member *Date*

Frank Gutierrez, LCPC *Date*

