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POLICIES AND PROCEDURES PERTAINING TO PERSONAL HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.

Healthcare Components in the Hybrid Entity Covered by this Notice

Mary Ellen Agolia, Ph.D. is a covered entity under HIPAA law. This notice applies to the privacy practices in this office. I understand the importance of your Protected Health Information (hereafter referred to as "PHI") and follow strict policies (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you, or the payment for that care.

In this notice, how to protect the privacy of your PHI, and how it will be allowed to be used and given out ("disclosed") is explained. I am required to provide you with a summary of my Notice of Privacy Practices, and a copy of the Notice of Privacy Practices upon request. I must follow the privacy practices described in this notice while it is in effect. This notice took effect January 1, 2008, and will remain in effect until it is replaced or modified. I reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. These revised practices will apply to your PHI regardless of when it was created or received. Before any material change to the privacy practices, a revised Notice of Privacy Practices will be provided to you.

Where multiple state or federal laws protect the privacy of your PHI, the requirements that provide the greatest privacy protection will be followed. For example, when you authorize disclosure to a third party, state law requires me to condition the disclosure on the recipient's promise to obtain your written permission to disclose to someone else.

I do not sell your PHI to anyone or disclose your PHI to other entities without your permission. I must have your written authorization to use and disclose your PHI, except for the following uses and disclosures;

• To You:

I may disclose your PHI to you, for example:

- Supplying you with information about your diagnosis or treatment
- Communicating with you about treatment alternatives or other health-related services

• For Treatment:

I may use and disclose your PHI to health care providers who request PHI in connection with your diagnosis, treatment, management or your care, coordination of benefits, and insurance eligibility, for example:

- Facility mental health staff, licensed and interns
- Referring you to an outside provider

• For Payment:

I may use and disclose your PHI for payment-related activities and those of health care providers and health plans, including for example:

- Obtaining premiums and determining eligibility for benefits
- Responding to inquiries, appeals and grievances
- Coordinating benefits with other insurance you may have
- Billing you or a health plan for health care services provided to you through this office
- Submitting a claim form on your behalf

• For Health Care Operations:

I may use and disclose your PHI for the following health care operations, for example:

- Performing business management and other general administrative activities, including systems management and customer service
- Scheduling appointments and keeping records

• To Others Involved In Your Care:

I may disclose your PHI to someone who has the legal right to act on your behalf. I may under certain circumstances disclose to a designated contact person (e.g.: a member of your family, a relative, a close friend or any other person you identify), the PHI directly relevant to that person's involvement in or payment for your healthcare. For example, I may discuss a claim determination with you in the presence of a friend or relative, unless you object.

• When Required by Law:

I will use and disclose your PHI if I am required to do so by law. For example, I will use and disclose your PHI

- To respond to court and administrative orders and subpoenas
- To report suspected abuse and neglect to the proper authorities
- To report PHI as required by the Secretary of Health and Human Services and state regulatory authorities
- To report threats to safety or self or others

• To Business Associates:

From time to time I may engage third parties to provide various services. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, I will have a written contract with that third party designed to protect the privacy of your PHI. For example, I may share your information with business associates who process claims on my behalf.

Disclosures You May Request

You may instruct me and give your written authorization to disclose your PHI to a designated individual or agency for any purpose. I require that your authorization be in a standard form.

You have the following rights. To exercise these rights, you must make a written request on my standard form.

• **Access:** With certain exceptions, you have the right to look at or receive a copy of your PHI contained in the group of records that are used by or for me to make decisions about you, including enrollment, payment, claims adjudication, and case or medical management notes. I reserve the right to charge a reasonable cost-based fee for copying and postage. If you request an alternate format, such as a summary, a cost-based fee for preparing the summary may be charged. If your request for access has been denied, you will be informed about the basis for the decision and whether you have a right to further review. You may request access to PHI in an alternative communication format and/or location.

• **Disclosure Accounting:** you have the right to an accounting of certain disclosures of you PHI, such as disclosures required by law.

• **Restriction Requests:** You have the right to request that restrictions be placed on the way your PHI for treatment, payment or health care operations is used and/or disclosed. I am not required to agree to these additional restrictions, but if agreed upon, they will be abided by (except as needed for emergency treatment or as required by law) unless you are notified that our agreement is going to be terminated.

• **Revoke Prior Authorization:** You may revoke your authorization, except to the extent that I have taken action upon it.

• **Amendment:** You have the right to inspect PHI and request that it be amended in the set of records described above under Access. If your request is denied, you will be provided with a written explanation. If you disagree, you may have a statement or your disagreement placed in your records. If your request to amend the information is accepted, reasonable efforts will be made to inform others of the amendment, including individuals you name.

• **Confidential Communication:** I communicate decisions related to payment and benefits, which may contain PHI, to the subscriber. Individual members who believe that this practice may endanger them may request that we communicate with them using a reasonable alternative means or location. For example, an individual member may request that we send an Explanation of Benefits to a post office box instead of the home address.

I have read the policies and procedures pertaining to personal health information. I understand my rights and responsibilities.

Client Signature _____

Date _____

Provider Signature _____

Date _____