

Notice of Privacy Practices for Kristine Martin, LPCC

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

Your health record contains personal information about you and your health. This information about you may identify you, including as it relates to your past, present and future physical or mental health or condition AND related health care services and is referred to as *Protected Health Information* (“PHI”). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPPA”), regulations promulgated under HIPPA, including the **HIPPA Privacy and Security Rules**, and the *NASW Code of Ethics and the Minnesota Board of Psychology*. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of the Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. I will provide you with a copy of the revised Notice of Privacy Practices via email, sending a copy to your home address or providing one at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

- **For Treatment:** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I am authorized to disclose PHI to any other consultant only with your written permission.
- **For Payment:** I may use and disclose PHI so that we can receive payment for services provided to you. This will only be done with your authorization. Examples of payment related activities are: confirming eligibility with insurance providers including HSA and FSA spending accounts. If it becomes necessary to utilize collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for the purposes of collection.
- **For Health Care Operations:** I may use or disclose your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g. billing or typing services) provided I have a written contract with the person or business that requires it to safeguard the privacy of your PHI.
- **Required by Law:** Under the law, we must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule,

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Without Authorization: Following is a list of the categories of uses and disclosures permitted by **HIPPA** without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations:

As a Psychologist, licensed by the state of Minnesota, it is my practice and duty to adhere to more stringent privacy requirements for disclosure without authorization. The following language addresses these categories to the extent consistent with the **Minnesota Board of Psychology and HIPPA**.

- **Child Abuse or Neglect:** I may disclose your **PHI** to a state or local agency that is authorized by law to receive reports of child abuse or neglect.
- **Judicial and Administrative Proceedings:** I may disclose your **PHI** pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
- **Deceased Patients:** I may disclose **PHI** regarding 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. **PHI** of persons that died 50 years ago or longer is not protected under **HIPPA**.
- **Medical Emergencies:** I may disclose your **PHI** in a medical emergency to a medical professional only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as is reasonably possible after the resolution of the emergency.
- **Family Involvement in Care:** I may disclose your **PHI** to close family members or friends directly involved in your treatment based on your consent or to prevent serious harm.
- **Health Oversight:** If required to do so, I may disclose your **PHI** to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to programs (such as third party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement:** I may disclose your **PHI** to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document for the purpose of identifying a suspect, material witness or missing person, in connection with 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.
- **Required by Law:** Under the law, I must disclose your **PHI** to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.
- **Specialized Government Functions:** I may review requests 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.
- **Public Health:** If required, I may use or disclose your **PHI** for mandatory health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

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- **Public Safety:** I may disclose your **PHI** to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed in these circumstances, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Research:** **PHI** may only be disclosed after a special approval process or with your authorization.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written permission, which may be revoked at any time, except to the extent that I have already made use or have disclosed information based on your prior authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of **PHI** for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of **PHI**; and (iv) other uses and disclosures not described in this **Notice of Privacy Practices**.

YOUR RIGHTS REGARDING PHI

You have the following rights regarding PHI that we maintain about you. To exercise any of these rights, please submit your request in writing to me at Kristine Martin, 8100 Penn, Avenue S, Suite #155 Bloomington, MN 55431.

- **Right of Access to Inspect and Copy:** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy **PHI** that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only to those situations where there is compelling evidence that access would cause serious harm to you or if the information contained in separately maintained physiotherapy notes, I may charge a reasonable fee for copies. If your records are maintained electronically, you may also request an electronic copy of your **PHI**. You may also request that a copy of your **PHI** be provided to another person.
- **Right to Amend:** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy.
- **Right to an Accounting of Disclosures:** You have the right to request an accounting of certain of the disclosures that we make of your **PHI**. We may charge a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions:** You have the right to request a restriction of limitation on the use or disclosure of your **PHI** for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of **PHI** to a health plan for purposes of carrying out payment or health care operations, and the **PHI** pertinent to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.

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- **Right to Request Confidential Communication:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask for an explanation of why you are making this request.
- **Breach Notification: If there is a breach of unsecured PHI** concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice:** You have a right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing to me at: Kristine Martin, 8100 Penn Ave. S., #155, Bloomington MN 55431 or with the Secretary of Health and Human Services at 200 Independence Avenue S.W., Washington D.C. 20201 or by calling (202)619-0257. I will not retaliate against you for filing a complaint.

Signature _____ Date _____

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