**NOTICE OF PRIVACY PRACTICES**

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

*The Health Insurance Portability and Accountability Act (HIPAA) provides protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient/client protections related to the electronic transmission of data (“the transaction rules”), the maintenance and use of client records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are required to provide client a notification of their privacy rights as it relates to their health care records.*

*This Client Notification of Privacy Rights is AmaTodos Ministries LLC way of informing you of your rights in a comprehensive fashion. Please read this document carefully, it is important you to know and understand what client protections HIPAA affords. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship. Therefore, I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to contact me directly at 931-240-3627 or by email at dorimar\_santiago@outlook.com.*

*By law, AmaTodos Ministries LLC is required to secure your signature indicating you have received this Client Notification of Privacy Rights Document. Thank you for taking the time to carefully review this document and provide your signature acknowledging receipt.*

*Tennessee requires authorization and consent for treatment, payment and healthcare operations. HIPAA does nothing to change this requirement by law in Tennessee. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your Consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care.*

*When/if the need arises requiring me to send any of your protected health information to anyone outside of my office, you will be required to first sign a Release of Information form identifying clearly the name of the point of contact, address, title and reason for request for the outside party receiving your information. A copy of the Release of Information form is available upon request and may be electronically signed through your Client Portal account or provided in hardcopy upon request. The requirement of you to sign a Release of Information form is an added protection to secure the confidentiality of your protected health information (PHI).*

*I. MY PLEDGE REGARDING HEALTH INFORMATION:*

*I understand mental health information about you and your psychological wellbeing is personal. I am committed to protecting mental 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 comply with certain legal requirements. This notice applies to all of the records of your care generated by this 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:*

* *Make sure protected health information (“PHI”) identifying you is kept private.*
* *Give you this notice of my legal duties and privacy practices with respect to health information.*
* *Follow the terms of the notice that is currently in effect.*
* *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 client to use or disclose the client’s personal health information without the client’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 health care provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the health care provider in diagnosis and treatment of your condition.*

*Disclosures for treatment purposes are not limited to the minimum necessary standard. Because 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:*

1. *Session Notes: I maintain “Session notes” 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 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 mental health oversight activities pertaining to the originator of the session notes.*

*h. Required to help avert a serious threat to the health and safety of others.*

1. *Marketing Purposes. As a mental health care provider, I WILL NOT use or disclose your PHI for marketing purposes.*
2. *Sale of PHI. As a mental health care provider, I WILL NOT sell your PHI in the regular course of my business.*

*IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.*

*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 preventing or reducing a serious threat to anyone’s health or safety.*
3. *For health oversight activities, including audits and investigations.*
4. *For judicial and administrative proceedings, including responding to a court or administrative order, you will be required to complete a Release of Information for before I complete this request.*
5. *For law enforcement purposes, including reporting crimes occurring on my premises.*
6. *Appointment reminders and document completion reminders.*
7. *I will use your email to register you to complete the ARNO Temperament questionnaire.*
8. *I may use your email to provide you an invitation to complete a Prepare-Enrich questionnaire for future use in Premarital or Marriage Counseling sessions.*

*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:*

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.*
2. *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.*
3. *The Right to View and obtain copies of your PHI. Other than “session notes,” you have the right to obtain an electronic or paper copy of your medical record and other information that I have about you without charge. 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.*
4. *The Right to Obtain a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or mental health care operations, or for which you provided me with a signed Release of Information form. 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, however if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.*
5. *The Right to Correct or Update Your PHI. If you believe there is a mistake in your PHI, or a piece of important information is missing from your PHI, you have the right to request 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.*
6. *The Right to Obtain a Paper or Electronic Copy of this Notice. You may access your account in the Client Portal to obtain a copy of this notice electronically or request a paper copy of this notice, and you have the right to get a copy of this notice by e-mail.*

*EFFECTIVE DATE OF THIS NOTICE*

*This notice went into effect on January 12, 2022*

*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 access to this document in your Client Portal account and understand you may request receipt of a copy of HIPAA Notice of Privacy Practices in hardcopy.*

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SIGNATURE DATE