

POSITIVE YOUTH CONCEPTS

Child and Adolescent Therapy

24 Front Street, Suite 302

Exeter, NH 03833

603-418-7480

NEW HAMPSHIRE NOTICE OF CLIENT RIGHTS FORM

Notice of Clinicians' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.

To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”

Treatment - is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

Payment - is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations - are activities that relate to the performance and operation of my practice.

Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- “Use” applies only to activities within my practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.

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II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have a reason to suspect that a child has been abused or neglected, I am required by law to report this to the Bureau of Child and Family Services.

Adult and Domestic Abuse: If I suspect or have a good faith reason to believe that any incapacitated adult has been subject to abuse, neglect, self-neglect or exploitation, or is living in hazardous conditions, I am required by law to report that information to the Commissioner of the Department of Health and Human Services.

Health Oversight: If the New Hampshire Board of Psychological Examiners, the New Hampshire Board of Medicine, or the New Hampshire Board of Mental Health Practice is conducting an investigation, then I am required to disclose your mental health records upon receipt of a subpoena from the Board.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I provided you and/or the records thereof, such information is privileged under state law, and I may not release information without your written authorization, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.

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Serious Threat to Health or Safety: If you have communicated to me a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or if you have made a serious threat of substantial damage to real property, I am required by law to take reasonable precautions to provide protection from such threats by warning the victim or victims of your threat and to notify the police department closest to your residence or the potential victim's residence, or obtain your civil commitment to the state mental health system.

III. Patient's Rights and Clinician's Duties

Patient's Rights

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

• **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

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I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will give you notice either by mail or in person.

IV. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me and I will work to resolve them. If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to me and I will address your complaint. You may also file a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

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Upon initial evaluation or intake, I _____ was given a copy of New Hampshire Notice of Clients Rights. I have had the opportunity to review them and ask any questions. I am also aware that a copy of the American Counselors Association Code of Ethics is available to me upon request any time.

Parent/Guardian

Signature: _____ Date: _____