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### **HIPAA Notification**

#### **Notice of Policies and Practices to Protect the Privacy of Your Health Information**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health and related health care services 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. 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 to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

#### **HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

I may use or disclose your Protected Health Information (PHI) for treatment, payment, and for the purpose of health care operations with the consent you have provided by signing my "Disclosure and Consent to Treatment" form, or in certain cases, by requesting that you sign a specific Authorization allowing me to disclose health care information about you.

**For Treatment:** When I provide you health care or manage it, for example by seeking a consultation with another health care professional as a way of better serving your needs.

**For Payment:** I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. 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 or legal action due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations:** I may use or disclose, as needed, your PHI to support the related to the performance and operation of my practice. Examples of health care

operations are quality assessment and improvement activities. If government agencies require records for the purposes of mental health quality management, your personal information will be removed.

**As Required by Law:** Under the law, I must make disclosures of 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.

### **USES AND DISCLOSURES REQUIRING AUTHORIZATION**

By signing an Authorization form, you allow me to use or disclose information about you for purposes of treatment, payment, and health care operations. This provides specific permission above and beyond that which you have given by signing my “Disclosure and Consent to Treatment” form. I will request that you sign an Authorization form if I am asked to release information for purposes of your treatment elsewhere, payment, or health care operations. I will also need you to sign an Authorization form if you request that I release your Progress Notes.

These are notes that I have made for my use to assist me in providing the best care possible. These notes contain very sensitive material and are not written with the intention of being released, so they are given a higher degree of protection than PHI. You may revoke all authorizations at any time by written consent. You may not, however, revoke an authorization if I have already taken action on it based on your prior signature. Further, if the authorization was obtained as a condition of acquiring or using insurance benefits, your insurance company has a legal right to receive information to contest a claim.

### **USES AND DISCLOSURES NOT NEEDING CONSENT OR AUTHORIZATION**

Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization include the following:

\*If I have reasonable cause to believe that a child has been abused or neglected, I am required to report my suspicion to the Department of Human Services.

\*If I have reasonable cause to believe that an elderly person or other vulnerable adult has been abused, abandoned, exploited or neglected, I am required to report my suspicion to the Department of Human Services.

\*If the Washington State Department of Health subpoenas me as part of an investigation, I am required to comply and may be asked to disclose your PHI.

\*If you are involved in a legal proceeding and a request is made for information regarding the services I have provided. Your PHI is privileged under State law, however, I must release your PHI if I am presented with a signed Authorization from you or your representative, if I receive a properly executed subpoena and you have failed to inform me that you are contesting the subpoena, or if I am ordered to release your PHI by a court of law. This privilege does not apply when you are being evaluated by order of the court or for a third party.

\*If you are or were a member of the armed forces, or part of the national security or intelligence communities, military command or other government authorities may require the release of health information about you.

\*If, in my professional judgment, you are likely to harm yourself, I may notify a family member, a friend of yours, and/or disclose information necessary to seek hospitalization to assist in maintaining your safety. If I have reason to believe that you have intent to harm someone else or pose a health threat to the community, I may disclose information to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

\*If you file a Worker's Compensation claim, I must make available any PHI in my possession that is relevant to your particular injury. Relevance is determined by the Department of Labor and Industries. This department, along with your employer and any personal representative can request your PHI.

### **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request to me in writing.

\***Right to Revoke Your Consent.** You have the right to revoke your consent at any time with written notice. Your revocation will be effective when I receive it, but will not apply to any uses or disclosures that occurred prior to that time.

\* **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 may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I reserve the right to charge a reasonable, cost-based fee for copies.

\* **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.

\* **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that I make of your PHI. I may charge you 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 or 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.

\* **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

\* **Right to a Paper Copy of This Notice.**

### **COMPLAINTS**

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Ave., SW, Washington, DC 20201 or by calling (202)-619-0257.