



NOTICE OF PRIVACY PRACTICES

YOUR RIGHTS:

Receive an electronic or paper copy of your treatment record:

- ✓ You can ask to see or get an electronic or paper copy of your record and other health information that I have on file about you.
- ✓ I will provide a copy or a summary of your health information, within 30 days of your request. For paper copies: I may charge a reasonable, cost-based fee to cover the cost of printing and postage.

Ask for corrections to be made in your medical record:

- ✓ You can ask me to correct health information about you that you think is incorrect or incomplete.
- ✓ Please note that certain information cannot be “deleted” from your record once officially entered, though I can “strike” or add an addendum to correct it.
- ✓ I may say “no” to your request, but I will tell you why in our next appointment and/or in writing within 30 days of the request.

Request confidential communications:

- ✓ My office policy is to maximize the security and confidentiality of all our communications, including using HIPAA-compliant platforms for telehealth sessions, phone calls, and encrypted / secure messaging or email.
- ✓ Unless absolutely necessary, I discourage the use of communication via unsecure methods (e.g., regular SMS/text messaging, unencrypted email), though will do so sparingly if necessary.
- ✓ You can ask me to contact you in a specific way (e.g., your preferred phone number, a specific email), or to send mail to a different address.

Continued next page...

YOUR RIGHTS:

Ask me to limit what information I use or share:

- ✓ **I cannot and will not share any of your information with anyone** (including even acknowledging that I know or have met you in any capacity, including your family members, lawyers, doctors, etc.) **except in the following cases:**

- I have your **written permission** (via a signed Release of Information form).
- You have a **legal guardian or conservator**.
- You are using **health insurance** to pay for my services, in which case I must submit certain limited information to your health insurance provider so that they can process the claim and pay for my services.
- You are seeing me as part of a **worker's compensation** claim. Legally, I am required to submit my documentation for substantiation of treatment. Please note that once your information is released to worker's compensation, I no longer have control of its subsequent release.
- I am legally and professionally obligated to report concerns of **abuse** or **neglect** of vulnerable persons to Child or Adult Protective Services.
- I have reason to suspect you are at an **immediate risk** of **suicide** or **homicide**. It is my duty to protect both you and others from imminent harm.
- I have received a **court order**, signed by a judge, to release your information.
- On rare occasion (in my experience), your **health insurance has the ability to audit your records**. If so, I may be obligated to release your information (including treatment notes) to fulfill this audit request.

- ✓ In all cases above, I will strive to release only the very **minimum** information to fulfill my obligation to the request as a means of protecting your privacy.

Continued next page...

- ✓ You can ask me not to use or share certain health information for treatment, payment, or my office operations; however, some information disclosures may still be necessary. I will do the best of my ability to limit required disclosures to the minimum required information if so.

YOUR RIGHTS:

Get a list of those with whom we've shared information:

- ✓ You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why.
- ✓ I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). I will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

- ✓ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. For paper copies, I will provide you with a paper copy promptly, sent by mail.

Choose someone to act for you:

- ✓ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- ✓ I will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights have been violated:

- Please inform me if you feel I have violated your rights; you may discuss this during our next appointment, or via any of our established secure/encrypted communication channels.

Continued next page...

- ✓ You may file a complaint with the Tennessee Board of Examiners of Psychology (who issue and maintain my license as a Clinical Psychologist and Health Service Provider) by calling **1-800-852-2187** or emailing **oiv.complaints@tn.gov**.
- ✓ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **1-877-696-6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- ✓ I will not retaliate against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell me your choices about what and with whom I share your information. If you have a clear preference for how I share your information in the situations described below, let me know.

With a written release of information, you have both the right and choice to tell me to:

- ✓ Share information with your family, spouse, close friends, caregivers, other treatment professionals or others involved in your care.
 - *Please note, I may choose to not release certain information to certain individuals, even if requested, if I anticipate it may result in harm to you or other associated entities. This can be discussed further.
- ✓ If you are not able communicate your preference, for example, if you are unconscious or incapacitated, I may share your information to your designated emergency contact if I believe it is in your best interest.

I will never share your information in the following circumstances:

- Marketing purposes.
- Sale of your information.
- Any disclosure without a written release (or meeting the exception criteria as previously listed on **page 2** of this document).

Continued next page...

MY USES & DISCLOSURES: -----

For permitted, appropriate, and indicated situations, I typically use or share your information in the following ways:

For your treatment:

- ✓ With your written permission, I can use your health information and share it with other professionals who are treating you to help coordinate your care (e.g., your psychiatrist, counselor, physical therapist, primary care doctor). For example, I may share your diagnosis and treatment progress with your physician, who may make medication adjustments for you based off of this information.

Consult with your attorney (if applicable)

- ✓ With your permission, it may be beneficial for me to consult with your attorney as a means of advocating for services (e.g., relating to your worker's compensation claim) and for me to better understand the nature and status of your legal case as it pertains to our treatment plan. Your attorney may also wish to receive information and updates from me to inform your legal case.
- ✓ I am in no way obligated to speak to or provide information to any attorney without your permission unless I am compelled by court order.

Bill for your services

- Again, if you are using your health insurance to pay for my services, I can and do have to share certain information with your health insurance carrier to bill and get payment (including your worker's compensation case manager and/or adjusters if applicable). This typically must include: your name, date of birth, address, dates of service, diagnoses, and treatment codes.

Help with public health and safety

- Reporting suspected abuse, neglect of children or other vulnerable persons.
- Preventing or reducing a serious threat to someone's health or safety (including in the anticipated event of imminent suicide or homicide).

Continued next page...

MY USES & DISCLOSURES: -----

Coordination of worker's compensation care:

- ✓ If you are involved in worker's compensation and your care is coordinated and paid for by worker's compensation services, I will need to be in contact with your case manager and/or adjuster as well as send treatment notes to coordinate your care.

Respond to lawsuit and/or other legal actions:

- ✓ I am legally obligated to release information requested by a **court order**.
- ✓ All other requests for releases of information for legal purposes will be denied unless I have your written permission via a signed Release of Information.

MY RESPONSIBILITIES: -----

- ✓ I am required by my professional code of ethics, as well as state and federal law to maintain the privacy and security of your protected health information.
- ✓ I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- ✓ I must follow the duties and privacy practices described in this notice and give you a copy of this notice.
- ✓ I will not use or share your information other than as described in this notice. If you have permitted me to release your information, you may change your mind at any time and revoke your permission for subsequent disclosures.
- For more information, see: <https://www.hhs.gov/hipaa/index.html>

CHANGES TO THE TERMS OF THIS NOTICE:

- I can change the terms of this notice, and the changes will apply to all health information in your file. New notices will be available upon request, electronically and paper copies, and on my website.



Renew Psychology
Rehabilitation and Neuropsychology Services PLLC

Rebecca J. Cicha, Ph.D., ABPP-RP

Phone: (423)-295-8335

Fax: (423)-295-9318

Website: renew-psychology.com