

Debra Haverson Psychotherapy Associates  
Madison, NJ

**Notice of Privacy Practices**

This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your protected health information. Please review it carefully.

**HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED:**

**Treatment.** With your written consent only, I will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and related services. For example, your protected health information may be provided to a doctor or treatment team member to whom you have been referred to ensure that the doctor or treatment team member has the necessary information to diagnose or treat you.

**Payment.** Your protected health information will be used, as needed, in activities related to obtaining payment for your health care services. For example, obtaining approval for a hospital stay or residential treatment program may require that your relevant be disclosed to your health insurance company to obtain approval for the admission.

**Business Associates.** I may use or disclose your protected health information with third party “business associates” that perform various activities (e.g. billing services). If ever an arrangement between a business associate and me involves the use or disclosure of your protected health information, I will have a written contract from them that contains terms that will protect the privacy of your protected health information.

**Written Authorization.** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

**Opportunity to Object.** I may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

**Others Involved in Your Healthcare.** Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that relates to that person’s involvement in your health care.

**Emergencies.** In an emergency situation, your provider shall try to provide you a Notice of Privacy as soon as reasonably practical after the delivery of treatment.

**Without 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 are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory
- government agency audits or investigations (such as the health department)
- Required by Court Order

- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

## **YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

- **Right To Inspect and Copy your protected health information.** However, I may refuse to provide access to certain psychotherapy notes or information for a civil or criminal proceeding.
- **Right to Amend.** You may request an amendment of protected health information about you. If I deny your request for amendment, you have the right to file a statement of disagree with me and your medical record will note the disputed information.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that I may have made for purposes other than treatment, payment or healthcare operation. It excludes disclosures I may have made to you, for a facility director, to family members or friends involved in your care, or for notification purposes
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your protected health information for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about your health information in a certain way or at a certain location. I may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address of other method of contact.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.
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## **COMPLAINTS**

If you believe that I have violated your privacy rights, you have the right to file a complaint in writing with me 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. You may file a complaint without fear of retaliation.

**Receipt and Acknowledgement Page Follows in this document.**

**Please bring any contact information for doctors, educators or others you wish me to consult with about your care (or the client's). You will need to fill out and sign HIPAA Privacy Authorization Forms to agree to have both myself and the other provider share information.**

Debra Haverson Psychotherapy Associates, Madison, NJ

**Notice of Privacy Practices  
Receipt and Acknowledgment of Notice**

The passage of the federal “medical records privacy law” known as HIPAA (Health Insurance Portability and Accountability Act) requires that I give you a copy of this document and to secure your signature indicating you have received a copy of it.

**Client Name:** \_\_\_\_\_

Please sign below to acknowledge that you have been given an opportunity to read this Notice of Privacy Practices. This page will be placed in your client file to indicate you have been provided with a copy of the Notice of Privacy Practices under HIPPA as required by law.

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**Signature of Client**

**Date**