Sundstrom
CLINICAL SERVICES

Notice of Privacy Practices & Limitations of Confidentiality

Effective date: 10/6/2006

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

Mental health treatment may be somewhat unique from other healthcare. Please read this document regarding how your private information will be protected and the circumstances under which we would be required to release confidential information. Please be aware of the following:

- Licensed Psychologists follow the APA Ethical Principles of Psychology and Code of Conduct regulated by the Oregon Board of Psychology (OBOP).
- Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) follow the Code of Ethics regulated by the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT).
- Certified Pediatric Nurse Practitioners-Primary Care (CPNP-PC) and Psychiatric-Mental Health Nurse Practitioners-Board Certified (PMHNP-BC) follow the Oregon Nurse Practice Act regulated by the Oregon State Board of Nursing (OSBN).

As a client at Sundstrom Clinical Services, I understand that I have the following rights:

- To expect that a licensee has met the qualifications of training and experience required by state law.
- To examine public records maintained by the Board and to have the Board confirm the credentials of a licensee.
- To obtain a copy of the Code of Ethics (Oregon Administrative Rules 833-100).
- To be informed of the cost of professional services before receiving the services, in conjunction with member verifying insurance benefit coverage.
- To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.
- To obtain an electronic or paper copy or summary of your medical record. We will provide a copy or a summary of your health information usually within 15 days of your request.
- To request us to correct health information about you that you think is incorrect or incomplete. SCS retains the right to say "no" to your request.

- To request confidential communications, or to ask us to contact you in a specific way (e.g., home, office, or cell phone).

- To ask us to limit the information we share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If we agree to your request, we may still share this information in the event you need emergency treatment. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- To get a list of those with whom we've shared your information.

- To choose someone to act for you. If someone has authority to act as your personal representative, such as a power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- To tell us your choices for how we share your information with your family, close friends, or others involved in your care. You also have the choice to tell us how to share your health information in the event of a disaster relief situation.

- To be notified if there is a breach of your unsecured health information.

- To get a paper copy of this Notice at any time, even if you agreed to receive it electronically.

- To revoke, in writing, any authorization you have given us, except for actions we have already taken.

I understand that my health information may include information both created and received by Sundstrom Clinical Services, LLC (SCS), may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

In general, **the law protects the privacy of personal health information between a client and a psychotherapist, and that SCS can only release information with my written permission.** In psychotherapy with couples, information on both is recorded in the same health record. If there is a need to release information, we will require written consent from both parties to release that information.

I understand there are exceptions and limits to confidentiality, and that SCS may be required to use and disclose my health information to:

- Make decisions about and plan for my care and treatment including consultation or coordination among with other health care providers for my care.

- Determine my eligibility for health plan or insurance coverage, and **submit bills, claims, or other information** to insurance companies or perform other administrative functions to arrange and be reimbursed for quality, cost-effective health care. We can use and share your health information to run our practice, improve your care, and contact you when necessary.

- Contact you as a reminder that you have an appointment with us. We may use and disclose health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you. We also make your health information available for you to access through a secure online patient portal.

- Create "deidentified" information that is not identifiable to any individual in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Federal law does not restrict the use of patient health information once it becomes "de-identified" data in a manner provided under HIPAA so as to not disclose your identity. We may use and disclose a limited data set only for research, public health or healthcare operations purposes.

- To perform other administrative functions with our business associates who perform functions on our behalf or provide us with services, if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated by law and under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

- **Comply with a court order or subpoena**. Often you have rights to prevent the release of information in legal matters. However, in some circumstances a judge may require our testimony. The scope of that testimony is limited only to the reporting of facts that occurred in the therapy office. **We cannot provide professional opinions in court testimony as this is a conflict with the role of a therapist. Professional evaluators should be sought for psychological opinions.** Providers also may share confidential information if defending claims brought by you against them.

- **Report suspected abuse, neglect, or domestic violence**. If SCS believes that a child, an elderly person, a disabled person, or animal is being abused, SCS is ethically bound to file a report with the appropriate state agency, which could require revealing confidential information. Master's Level Therapists and Nurse Practitioners have a legal requirement to report.

- **Take protective actions** if we believe a client is threatening serious bodily harm to themselves or someone else. These actions may include transfer to a higher level of treatment (e.g., hospitalization) or notification of family members that can help protect any potential victims, or the police. In these rare situations, we make every effort to discuss it with you prior and may seek professional consultation if we deem necessary.

- Share health information in the event that it is **legally required** for certain situations such as: preventing disease; reporting adverse reactions to medications; workers' compensation claims; law enforcement purposes; with health oversight agencies authorized by law.

We will get your written authorization before using or sharing your health information in ways not described in this Notice. We will also get your authorization before using or sharing psychotherapy notes (with limited exceptions), for marketing purposes, or in any sale of your health information.

We respect your privacy and are committed to protecting sensitive health information. This includes information about substance use. In compliance with the U.S. Department of Health and Human Services and the HIPAA Privacy Rule, we will only use or share this information as allowed or required by applicable federal or Oregon law. If we have substance use disorder records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

We are required by law to maintain the privacy and security of your protected health information, to give you this Notice of our legal duties and privacy practices, to notify you if a breach affects your information, and to follow the terms of this Notice currently in effect. We may change this Notice, and the new terms will apply to all information we hold. The current Notice is posted on our website and available at our office and on request.

THIS AUTHORIZATION DOES NOT PERMIT SUNDSTROM CLINICAL SERVICES TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER REQUIRED LAW.

SCS IS NOT IN SUPPORT OF GENERAL REGISTRIES OR REPORTING OF CLIENT INFORMATION BASED ON DIAGNOSES OR OTHER DEMOGRAPHIC IDENTIFIERS.

I understand that I have the right to receive and review a written description, known as a Notice of Privacy Practices, of how SCS will handle health information about me. This notice may be revised from time to time, and I understand that I am entitled to receive a copy of any revisions. I also have the right to ask that some or all my health information is not used or disclosed in the manner described in the Notice of Privacy Practices, but that SCS is not required by law to agree to such requests. I understand that if I have questions or concerns regarding the privacy of my health information I may contact JoMarie Erickson at Sundstrom Clinical Services at 503-653-0631 or jerickson@sundstromclinic.com.

I understand that if I feel my rights are violated, I can file a complaint with:

Licensed Psychologists: The Oregon Board of Psychology webpage (https://www.oregon.gov/psychology/pages/index.aspx) or 503-378-4154.

LPCs and LMFTs: The Board of Licensed Professional Counselors and Therapists webpage (https://www.oregon.gov/oblpct/pages/index.aspx) or 503-378-5499.

CPNP-PCs and PMHNP-BCs: The Oregon State Board of Nursing webpage (https://www.oregon.gov/osbn/pages/index.aspx) or 971-673-0685.

Any: The U.S. Department of Health and Human Services Office for Civil Rights by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

Your signature below indicates that you have read, understand, and consent to the procedures outlined in the Notice of Privacy Practices.

_____	_____
Client Name	Guarantor Name
_____	_____
Client or Guarantor Signature	Date

Permission to Exchange Prescription Health Information

I understand that Sundstrom Clinical Services uses Sure Scripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information.

I understand that signing this authorization is voluntary and that I have the right to revoke this authorization at any time by writing SCS- except for actions that have already been taken. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.

Your signature below indicates that you have read, understand, and consent to the above agreements regarding the exchange of prescription health information.

_____	_____
Client Name	Guarantor Name
_____	_____
Client or Guarantor Signature	Date