Pacific Sunrise Psychological Services
Kristi L. Mueller, Psy.D.
Clinical Psychologist
850 W Hind Dr, Ste 110, Honolulu HI 96821
(808) 859-2017

NOTICE OF PRIVACY POLICIES AND PRACTICES

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

The Health Insurance Portability and Accountability Act (HIPAA) requires that I provide you with this Notice of my privacy policies and practices, and that I obtain your signature acknowledging that you have received this Notice. If you do not understand any part of this notice, please ask for further explanation.

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

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operation purposes with your consent. To clarify these terms, here are some definitions:

PHI: refers to information in your health record that could identify you.

Treatment: 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 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 case coordination.

Use: applies only to activities within my office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.

Disclosure: applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties. The use and disclosure of psychotherapy notes and/or PHI for marketing purposes or those that constitute a sale of PHI require patient authorization. Other uses of disclosures not described in this notice will only be made once an authorization has been obtained. Patients may have the right to restrict certain disclosures of PHI to insurance companies if they are paying for services out of pocket in full. They also have the right to be notified following a breach of PHI.

II. Uses and Disclosures Requiring Authorization:

You may give written authorization for the use of disclosure of PHI for purposes other than treatment, payment, or health care operations. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. Written authorization is also needed for the release of psychotherapy notes, which are notes made during psychotherapy sessions, and which are kept separate from the rest of your clinical record. These notes are given a higher degree of protection than PHI. All authorizations may be revoked, in writing, at any time except to the extent that prior disclosure of information has already taken place.

III. Uses and Disclosures Requiring Neither Consent or Authorization:

Your PHI may be disclosed without your consent or authorization in the following circumstances:

Child Abuse: If I have reason to believe that child abuse or neglect has occurred or that there is a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future, I must immediately report the matter to the appropriate authority.

Adult and Domestic Abuse: If I, in the performance of my professional or official duties, know or have reason to believe that a dependent adult has been abused or is threatened with imminent abuse, I must promptly report the matter to the appropriate authority.

Serious Threat to Health or Safety: In situations in which there is clear and imminent danger to you, to another individual or society, it is my duty to take action to minimize the danger. This may involve the disclosure of PHI to appropriate professional workers or public authorities. If you are at risk, I may also contact family members or others who could assist in providing protection.

Health Oversight Activities: If the Hawaii Board of Psychology is investigating my competency, license or practice, I may be required to disclose protected health information regarding you.

Judicial and Administrative Proceedings: If you are involved in court proceedings and a request is made for information about the psychological services provided to you and/or the records thereof, such information is privileged under Hawaii law. I shall not release information without the written authorization of you or your legally appointed representative or at the direction of a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I shall inform you in advance if this is the case.

Worker's Compensation and Personal Injury Claims: If you have filed a Worker's Compensation, No Fault, or other personal injury claim, I may be required to disclose PHI about any services I have provided to you that are relevant to the claimed injury.

IV. Patient's Rights and Psychologist's Duties:

PATIENT'S RIGHTS:

Right to Request Restrictions: You have the right to request restrictions on uses and disclosures of PHI. I will attempt to accommodate reasonable requests, but I am not required to agree to a restriction.

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

Right to Inspect, Amend, or Copy: You have the right to inspect, request an amendment or obtain a copy of your PHI in my clinical and billing records for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but you may have this decision reviewed by a licensed health care professional for a second opinion. On your request I will discuss with you the details of the request and denial process. A fee may be charged for copies and/or postage.

Right to Accounting: You have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

Right to 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.

PSYCHOLOGIST'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.

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 post a notice of revision in my office.

V. Questions and Complaints:

If you have questions about this notice, disagree with a decision I make about your access to your records, or have other concerns about your privacy rights, you may contact me at 808-859-2017.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to: 850 W Hind Drive, Suite 110, Honolulu, Hawaii 96821.

You may also send 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.

VI. Effective Date, Restrictions, and Changes to Privacy Policy:

This notice will go into effect on 01 October 2013.

By signing below, I am indicating that I have read and understand the Privacy Policies and Practices above, and that any questions I have about this document have been answered to my satisfaction. I can obtain a copy of this policy at any time during my treatment and one has been offered to me today.

_____

Client signature

_____ _____

Printed Full name of Client (please print) Date

_____ _____

Dr. Kristi Mueller, Psychologist Date