Gina Borelli Moore, MA, MFT
Licensed Marriage & Family Therapist

Notice of Privacy Practices of Gina Borelli Moore, MFT

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. If you have any questions or requests about this notice, please contact Gina Borelli Moore, MFT.

Effective date: _____

State and Federal law require that I maintain the privacy of protected health information.
"Protected health information" is information I have created or received about your physical or mental health, the healthcare provided to you or payments for your healthcare if the information identifies you, or if a reasonable person would say that someone could use it to identify you. It includes your identity, diagnosis, dates of service, treatment plan and progress in treatment.

In addition, the law requires that I provide clients with this Notice of Privacy Practices. It explains our legal duties and privacy practices with respect to your medical and mental health information. It is also required to request that you sign the attached written acknowledgment that you received a copy of this Notice. This Notice describes how I may use and disclose your protected health information.

This Notice also describes your rights regarding your protected health information and explains how you may exercise your rights.

Uses and Disclosures of Protected Health Information

Permissible Uses and Disclosures Not Requiring Your Written Authorization.
I may use and disclose your medical and mental health information in the following ways:

Treatment: I may use and disclose your medical and mental health information to provide and coordinate your healthcare. I may use or disclose your medical and mental health information when I consult with another professional colleague, if I refer you for medication, or when I arrange coverage for being away. In any of these situations, we will provide only the minimum information necessary.

Payment: I will use your mental health care information for accounting and billing. If you consent, we will provide the minimum necessary information to your insurance company or other third party payer. The information can include information that identifies you, your diagnosis, dates and type of service, and limited information about your condition and treatment.

Health Care Operations: I may use and disclose your medical and mental health information for health care operations, including quality improvement activities, training programs, and obtaining legal services. I will only disclose necessary information.

Required or Permitted by Law: I may use or disclose your medical and mental health care information when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

Contacting the Client: You may be contacted to remind you of appointments and tell you about treatments or other services that might be of benefit to you.

Crimes on the premises or observed by the provider: Crimes that are observed by me, crimes that are directed toward me, or crimes that occur on the premises will be reported to law enforcement.

Business Associates: Business associates may provide some of the functions of the practice. For example, business associates may provide some of the billing, legal, auditing, ad practice management services. In those situations, I will provide only necessary protected health information to those contractors as needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

Involuntary Clients: Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

Family Members: Except for certain minors, incompetent clients, or involuntary clients, I cannot provide protected health information to family members without the client's consent. In situations where family members are present during a discussion with the client, and it is reasonable to infer from the circumstances that the client does not object, I may disclose information in the course of the discussion. However, if the client objects, I will not disclose protected health information.

Emergencies: In life-threatening emergencies, I will disclose information necessary to avoid serious harm or death.

Uses and Disclosures Requiring Your Written Authorization or Release of Information

Except as described above, or as permitted by law, other uses and disclosures of your medical and mental health information will be made only with your written authorization to release the information.

When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

Psychotherapy Notes: Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by me and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) I use them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and I have to defend myself; and (e) certain limited circumstances defined by the law.

Your Rights as a Client

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your medical and mental health information. However, I do not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the times of your request. Ask me for the Request Form.

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Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from me by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask me for the Request Form.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask me for the Request Form and the appeal process.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, I will attach it to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask me for the Request Form and the appeal process available to you.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures I have made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment payment and healthcare operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask me for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your medical and mental health information, except for action that has already taken place under you consent or authorization.

Copy of the Notice: You have a right to obtain a copy of this Notice upon request.

I am required to abide by the terms of this Notice, or any amended Notice that may follow. I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at my office and copies will be available upon request.

If you believe I have violated your privacy rights, you may file a complaint with me. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is my policy that there will be no retaliation for your filing of such a complaint.

Signature _____ Date _____

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