Form II:
HIPAA Notice

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404
MFT 28199

HIPAA NOTICE OF PRIVACY PRACTICES

(Note to therapists: Section I below must appear in your Notice of Privacy Practices exactly as it appears hereunder.)

I. 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.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website **(if applicable).** You may also request a copy of this Notice from me, or you can view a copy of it in my office or on my website, which is located at **(insert website address, if applicable).**

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

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I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

(Note to therapists: The following list is a compilation of federal and California laws)

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**

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3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. **If disclosure is otherwise specifically required by law.**

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C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via e-mail instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security pur-

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poses, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by E-mail. You have the right to get this notice by e-mail. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you**.**

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: **Nancy Gray, LMFT, 1111 Triton Drive, Suite 203, Foster City, CA 94404, 650-444-0433, meade7447@gmail.com**

VII. NOTIFICATIONS OF BREACHES

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In the case of a breach, **Nancy Gray, LMFT** requires to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, **Nancy Gray, LMFT** is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. **Nancy Gray, LMFT** bears the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VIII. PHI AFTER DEATH

Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. **Nancy Gray, LMFT** may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. INDIVIDUALS' RIGHT TO RESTRICT DISCLOSURES; RIGHT OF ACCESS

To implement the 2013 HITECH Act, the Privacy Rule is amended. **Nancy Gray, LMFT** is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring **Nancy Gray, LMFT,** to provide you, the patient, a copy of PHI if you, the patient, requests it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that **Nancy Gray, LMFT** must provide you only with an electronic copy of their PHI, not direct access to their electronic health record systems. The 2013 Amendments also give you the right to direct **Nancy Gray, LMFT** to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the amendments restrict the fees that **Nancy Gray, LMFT** may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days currently permitted to 30 days, with a one-time extension of 30 additional days.

X. NPP

Nancy Gray, LMFT NPP must contain a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

XI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on Jan. 30, 2013

I acknowledge receipt of this notice

Patient Name: ________________ Date:_____Signature: _______________

Patient Name: ________________ Date: ____Signature: _______________

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Form III:
Authorization to Release Information

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404
MFT 28199

AUTHORIZATION TO RELEASE INFORMATION

I, **(name of patient)** ______________________________, (hereinafter "Patient") hereby authorize **(name of psychotherapist) ____Nancy Gray, MED, LMFT______________** , (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

____

____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at:

1111 Triton Drive, Suite 203, Foster City, CA 94404

____ to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose: ____
The specific uses and limitations of the types of medical information to be discussed are as follows **(dates of service, therapy summary, information necessary to coordinate treatment, diagnosis, history)**

____

____

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Such disclosure shall be limited to the following specific types of information:

____

____

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: ___________________________________

Patient's signature: __________________________________

Date:___________________

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Form IV:
Request for Amendment of Health Information

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA
94404

MFT 28199

REQUEST FOR AMENDMENT
OF HEALTH INFORMATION

Date: ________
Patient name: ____
Birth date: _______________ Phone: ____________________________________
Patient address: ____
Describe the information you would like to have amended:
____
Date(s) of information to be amended (e.g., date of office visit(s):

____

____

What is your reason for making this request? (i.e., the information is incorrect, incomplete, or outdated) ____

____

How is the information you want to amend incorrect, incomplete, or outdated?

____

____

What should the entry say (or not say) to be more accurate or complete?

____

____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, health plan, or other health care provider)? Yes/No

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

____

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Signature of patient or legal representative: _____________
Date: ________________

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Form V
Tracking of Releases

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404 MFT 28199

Name of Patient	Date of Release	To Whom	Authorized by

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Form VI
Account of Disclosures

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA
94404 MFT 28199

Patient Name ______________________________________

Accounting Time Period (max. 6 years): From ___________________ to ______________

Here is the accounting of disclosures you requested.

As was articulated in the Notice of Privacy Practices, this document does not include disclosures made: (1) for treatment (e.g., if we referred you to another provider), (2) for payment (e.g., the claims filed with your health plan), (3) for health care operations (e.g., peer review of our work), (4) under any authorization that you signed, or (5) directly to you or your personal representative. There are additional exclusions to the disclosures we must account for.

For more information, contact our Privacy Officer, ______________________, at phone number: __________________________________.

No disclosures were made that do not fall under one of the exclusions.

#1: Date of the Disclosure: ________________
Person or Organization Receiving the Information: ______________________
Brief Description of the Information that was Disclosed:
____
Purpose of the Disclosure: ____

#2: Date of the Disclosure: ________________
Person or Organization Receiving the Information: ______________________
Brief Description of the Information that was Disclosed:
____
Purpose of the Disclosure: ____

When available, we may include a copy of a written request for disclosure in lieu of the above items.

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For a disclosure made more than once to the same recipient, the information above refers to the first disclosure.
The last disclosure made during this accounting period was on: ______

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Form VII
Denial of Access to Protected Health Information (PHI)

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404

MFT 28199

DENIAL OF ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

Patient Name ___________________________________

Normally, my patients are allowed access to their Protected Health Information (PHI), and/or a copy of it, whenever they request it, but there are a number of instances where I may deny this access. By law, access to your PHI may be denied for any of the following indicated reasons. You may have access to any information that is not covered by any of the reasons below.

The following reasons are not subject to review:

- The information exists only in Psychotherapy Notes (which are the private notes written by your therapist).
- The information has been compiled in reasonable expectation of legal proceedings, or for use therein.
- The information was obtained from another party to whom I promised confidentiality. Allowing access would reveal that person's identity, which would be an ethical breach.
- This information was generated or maintained during treatment that is part of a research project. Since that research is still in progress, the information is not immediately available; however, when the research study is completed, you may have access to the information.
- The requested information is not in my possession. It is obtainable from ___________________________________.
- Because you are an inmate in a correctional institution, giving you access to this information could conceivably jeopardize the safety, health, security, rehabilitation, or custody of yourself or other inmates.
- You are an inmate of a correctional institution; therefore, access to this information might jeopardize the safety of an officer, staff member, or other person at this institution, or a person responsible for transporting you.

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The following reasons <u>are</u> subject to review by a licensed health care provider, other than myself, in the event that you request a review of my decision.

- I believe that granting access to this information may possibly endanger the life or physical safety of you or another person.
- The information refers to another person (other than a health care provider) and it is possible that granting access to the information may cause significant harm to that person.
- You are the patient's personal representative and I believe that to grant you access would in all likelihood result in significant harm to that patient or some other individual.

How to Request a Review: Contact me directly if you would like to request a review of my decision. I will select a licensed health care professional to do the review and you will be notified of the decision. If the reviewer decides that access should be granted, I will grant it. If not, access will be denied.

Filing a complaint: Whether or not you request a review of my decision, you have the right to file a complaint against me. You may send your complaint directly to me, or, if you prefer, to my Privacy Officer:

Name and Number: ____

It is also your right to file a complaint with the Secretary of the U.S. Department of Health and Human Services. If you do, you must include my name and the nature of your complaint, i.e., denial of access. Your complaint must be written and must be sent within 180 days from the day of submission (although the Secretary may waive this time limit in some cases).

I regret that I cannot grant your request. I will be happy to discuss the matter with you at any time.

Sincerely,

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Form VIII
Denial of Request for Amendment

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404

MFT 28199

Denial of Request for Amendment

Patient Name ____________________________________

I try to ensure that the information in your records is complete and accurate. Nevertheless, mistakes can occur and, when they come to my attention, I correct them. You have requested that I amend your Protected Health Information (PHI). I cannot agree to amend your record for the reasons indicated hereunder.

- To the best of my knowledge, the information in your record is complete and accurate.
- You did not give enough information to make it clear that your records are incomplete or contain errors. Please provide me with any additional information you may have.
- The information you want to have amended is not part of the record that may be amended. The only part of the record that may be amended is that part containing your clinical and billing information or any part of the record used to make decisions about your care.
- The information is contained in the record that the law and other regulations do not permit you to access. Please see the attached document that explains why you cannot access the information.
- You did not request the amendment in writing, as required.
- Someone other than myself created the information you want to amend. Please send your request to the individual who created the information.

Your Rights If You Disagree with My Denial

If you disagree with my decision to deny the amendment, you are entitled to file a Statement of Disagreement in writing. Please submit it to my Privacy Officer or me:

Name and Number: ____

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Note: A Statement of Disagreement must be reasonable in length. Also, I have the right to file a rebuttal to your Statement of Disagreement. If I do, I will ensure that you get a copy of my rebuttal.

A copy of your Statement of Disagreement and my rebuttal, or a summary of them, will accompany any future disclosure of the information in question.

If you do not wish to file a Statement of Disagreement, you still may request that I append a copy of your amendment request and a copy of my denial to this information whenever it may be disclosed in the future.

Filing a complaint

Whether or not you may request a review of my decision, it is still your right to file a complaint with me. It may be submitted directly to me, or to my Privacy Officer.

You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services. If you do, you must include my name and the nature of your complaint, i.e. denial of amendment. Your complaint must be in writing and must be sent within 180 days from the day of submission (although the Secretary may waive this time limit in some cases).

I regret that I cannot grant your request. I will be happy to discuss the matter with you at any time.

Sincerely,

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Form IX: Complaint Form

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404

MFT 28199

Sample Complaint Form

Under HIPAA, you have the right to file a complaint with this office regarding our privacy practices, including our Notice of Privacy Practices and other privacy procedures. If you are not satisfied with your experiences here, we want to hear from you so that we can provide our services to you in ways that we both find satisfactory. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services at 200 Independence Ave. S.W. Washington, D.D. 20201.

If it is a clinical matter, we encourage you first to speak with your treating therapist. If it is an administrative-privacy concern, you can talk to our Privacy Officer, ________________________. If you are not satisfied or the problems still continues, please fill out this simple form and I assure you it will be investigated. We will try our best to fix it and to repair any damage that has been done. Also, I promise you that we will not in any way limit your care here or take any actions or retaliation against you if you bring a problem to our attention. You are entitled to receive a copy of this complaint.

Client's name ______________________________ Date of birth _________

Identification No. ________________ Telephone number _______________

Client's address____

What is or was the problem?

____

What would you like to see done about the problem? ___________________________

Signature of client or his/her personal representative: ___________________________
Date: ____

Printed name of client/personal representative: ____________________ Relationship to client: ___

Privacy Officer: __Nancy Gray, LMFT__________________ Phone: 650-444-0433_

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Note: The Privacy Officer must respond to the client's complaint within 30 days from the time that s/he receives this form.

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Form X:
Acknowledgement of Receipt of Notice of Privacy Practice

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404

MFT 28199

Acknowledgement of Receipt of Notice of Privacy Practice

I, ______________________________________, have received a copy of this Office's Notice of Privacy Practices.

Patient name: ____________________________

Signature: _______________________________ Date: ___________

It is your right to refuse to sign this document

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

________ **Patient refused to sign.**

________ **Communication barriers prohibited obtaining the acknowledgement.**

________ **An emergency situation prevented this office from obtaining it.**

________ **Others:** ____

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Form XI:
Breach Assessment
Nancy Gray MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA
94404 MFT 28199

Use this form to help you determine if a given security incident resulted in a "low probability of PHI compromise." In most cases, it may be necessary to consult with an expert to determine the answers to these questions. Answering them sometimes requires both technical knowledge and also knowledge of information system security issues. Before deciding on a final course of action after filling out this form, bring it to your attorney for guidance and advice.

Your security policies and procedures manual should contain a procedure that defines how you respond to security incidents. This form can be part of the procedure. Please note that the procedure should involve the early involvement of a qualified attorney so as to make sure you don't miss any ethically or legally required notifications during your process.

First: was the data "rendered unusable, unreadable, or indecipherable to unauthorized persons" at the time of the breach? Generally, full-device encryption with a strong encryption password is required to meet this condition. Consult with a security expert to be sure. **__Y __N**

If the answer is "Y," you may stop now. Bring the form to your attorney to confirm whether or not you need to perform any breach notification under HIPAA or state or local laws.

1. *The nature of the data that was misused or improperly disclosed:*
   - Did the data contain any personally identifying information about patients/clients? Refer to HIPAA's list of 18 identifiers for a list of things that can personally identify a patient/client. **__Y __N**
   - Is there a greater-than-low likelihood that the personally identifying data that was lost could be reasonably used to discover the identity of any patients/clients? **__Y __N**
2. *Who misused the information or received the unauthorized disclosure of the information:*

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- Are *any* of the persons who made an unauthorized misuse and/or who received the disclosed data still unidentified? **__Y __N**
  - If the answer is "Y," you must check "Y" for all other bullets under point 2.
- Was the person(s) who made an unauthorized misuse and/or who received the disclosed data **NOT** someone who is a member of your workforce or a Business Associate? If they are such a person, are they **NOT** otherwise in compliance with applicable security policies and with HIPAA? **__Y __N**
- Was the person(s) who made an unauthorized misuse and/or who received the disclosed data **NOT** a professional who is subject to privacy and security laws? I.e. was it private individual, including a thief or other malicious actor? **__Y __N**
- Was the person(s) who made an unauthorized misuse and/or who received the disclosed data **NOT** a family member or caregiver of the affected patient(s) and trusted by the affected patient(s)? **__Y __N**

3. *Was there a chance for the breached PHI to be retained?*
   - Did the person(s) who made an unauthorized misuse and/or who received the disclosed data actually retain the data? (e.g. Did they get a copy or do they have ahold of the original? Did they have opportunity to memorize it?) **__Y __N**
     - If you don't know the answer, check "Y."
4. *How was the incident handled?*
   - Did the handling of this security incident fail to render compromise of the affected PHI unlikely, in a confirmable way? (e.g. did you fail to confirm that a smartphone thief was prevented from unlocking the stolen phone? Did you fail to confirm that a misdirected FAX was shredded before it was disclosed to unauthorized individuals? Etc.) **__Y __N**

There is no scoring rubric that can answer whether or not breach notification is necessary. This is why it is important to consult with someone with the necessary expertise to understand the outcomes of the security incident being assessed.

The more numbered points that are mostly "Y"s, however, the more likely it is that you will need to report.

If you choose not to report, the burden is on you to prove that your decision was reasonable. Retain all documentation of the security incident and of your breach assessment for the so long as you retain HIPAA documentation.

It is strongly advised that you bring any breach assessments to an attorney before deciding whether or not to perform a breach notification.

Form XII
Authorization to use unencrypted e-mail and text

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404

MFT 28199

CONSENT TO USE UNENCRYPTED E-MAIL OR TEXT

It is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. Generally, e-mails, text messages, and e-faxes are not encrypted in transit over the Internet. It is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address and computers. Unencrypted e-mail or texts provide as much privacy as a postcard. You should not communicate any information to your health care provider that you would not want to be included on a postcard that is sent through the Post Office. E-mail messages on your computer, your laptop, tablet computer, phone or other devices have inherent privacy risks – especially when your e-mail access is provided through your employer or school or when access to your e-mail messages is not well protected.

Please, note that e-mails, faxes, and texts are all part of your clinical records.

Please notify ______________________________**Nancy Gray, LMFT** if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, it will be assumed that you have evaluated the risks and made an informed decision, ______________________________ **Nancy Gray, LMFT** will view it as your agreement to take the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

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Patient's Name: ______________________________
Cell Phone Number: _______________
E-mail Address: _______________________
In case that authentication is needed, please give me a password _______________
Patient's Signature: ______________________________________

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Form XIII
Patient's Right for Confidential Communication

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404

MFT 28199

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that **[provider's name]** communicates financial and/or medical information to you in confidence by a particular method or certain locations.

In order to protect the privacy and confidentiality of your information; please complete the following which tells me how you would like to be contacted.

I wish to be contacted in the following manner (check all that apply):

Phone Communications

____ Home Telephone Number ______________________________________

____ Work Telephone Number ______________________________________

____ Cell Phone Number ______________________________________

____ Do not contact me at home

____ Do not contact me at work

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____ Leave message with your name and call-back # on answering machine

____ Leave message with medical information on answering machine

____ OK to give information to following family member(s), friend/s or co-workers, or others listed below

____

Written Communication

___ Do not send written medical information to me

___ Mail information to my home address on file

___ Mail to my work/office address on file

___ Mail information to other address:

List ____________________________________

___ Fax to the following number ___________________________

___ I do not want to communicate by E-mail

___ You can communicate via E-mail with me at _______________________

Nancy Gray, LMFT will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form.

By your signature below, you agree to be communicated in the above manner.

Patient Signature ____

Patient Name ____

Date ______________

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Form XIV
Patient requests for restriction and termination of restrictions on use and disclosure of PHI.

NANCY GRAY MED, LMFT
1111 Triton Drive, Suite 203, Foster City, CA 94404

MFT. 28199

Patient request for restriction on use and disclosure of PHI

I request that **Nancy Gray, LMFT** restricts the use and disclosure of protected health information (PHI) listed below. I understand that **Nancy Gray, LMFT** may not agree to this request; provided, however, that **Nancy Gray, LMFT** may be required by law to grant a restriction preventing disclosure to my health plan concerning services or items for which I have paid **Nancy Gray, LMFT**.

Describe the restriction requested:

____
____

This restriction shall be in effect until (date or event):

____

Patient Name, printed: ____

Signature: ________________________________ Date: _______________

Relationship if not patient: ____

Mailing Address for future correspondence regarding this restriction:

____

Nancy Gray, LMFT has reviewed the above request to restrict the use and disclosure of protected health information (PHI) and ***(check one)***

__ Denies the request as **Nancy Gray, LMFT** cannot reasonably assure or guarantee the restriction can be met.

__ Accepts and will honor the request for the above stated restriction with the fol-

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lowing exceptions and conditions:

- If you need emergency treatment and the restricted PHI is needed to provide emergency treatment, I may use the restricted PHI or may disclose this information to another health care provider to provide you with the emergency treatment.
- I will ask the health care provider to not further use or disclose the PHI.
- To the extent permitted by law, I may need to terminate or revoke our acceptance of this restriction. Of course, I will notify you of such unilateral termination.

Therapist's Signature: ________________________________ Date: ________

Title: ____

Revoking or Terminating Restrictions of Use and Disclosure of Protected Health Information

Check One:

____ **Patient:** I hereby ***revoke*** the above restriction of the use and disclosure of my protected health information (PHI) effective _______________ (date).

____ **Nancy Gray, LMFT** previously agreed to the above restriction of the use and disclosure of your protected health information (PHI). To the extent permitted by law, **Nancy Gray, LMFT** ***terminates this previous agreement*** and no longer will restrict the use and disclosure of your protected health information effective ________________ (date).

Signed: ____ Date: _________

Printed Name: ____

Relationship if not patient: ____

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THE END

HAVE A HAPPY HIPAA DAY

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