

PATIENT NOTICE OF HIPAA PRIVACY PRACTICES

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations, which do not require authorization

Eclipse Counseling LLC may use or disclose your protected health information (PHI), for **treatment, payment, and health care** operations purposes. To help clarify these terms, here are some definitions:

- “HIPAA” refers to the Health Information Privacy and Accountability Act.
- “PHI” refers to information in your health record that individually identifies you.
- “Use” applies only to activities within the clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside the clinic, such as releasing, transferring, or providing access to information about you to other parties.
- “Treatment”, “Payment”, and “Health Care Operations”
 - **Treatment** – We may use or disclose your PHI to give you medical treatment or services, and to manage and coordinate your care. *For example, your PHI may be provided to another health care provider within Eclipse Counseling LLC, such as a clinician.*
 - **Payment** – We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as determining eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. *For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.*
 - **Health Care Operations** – We may use and disclose PHI for our health care operations. *For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you.*

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures, as noted above. In those instances when we are asked for information for purposes outside of treatment, payment, and healthcare operations, such as mental health and substance abuse notes, we will obtain an authorization from you prior to their release.

III. Uses and Disclosures with Neither Consent nor Authorization

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Note on Other Restrictions: *There may be state and federal laws that may have more stringent requirements than HIPAA regarding how we use and disclose your protected health information. Some of these have been specifically noted in this document. If there are more specific restrictive requirements, those laws will take precedence. Some of the laws discussing such restrictions are as follows: Wisconsin Statutes Sections 146.81 to 146.83, 51.30, and 908.03 (6m) (c); Wisconsin Administrative Code HFS 92, and 124.14; and 42 CFR Part 2 and 45 CFR Parts 160 and 164. If you would like a copy of these laws, please contact the clinic. Additional resources are available at: <https://www.dhs.wisconsin.gov/hipaa/resources.htm>*

- **Reporting Suspected Abuse, Neglect, or Violence** - If we have reasonable cause to suspect that a child seen in the course of our professional duties has been abused or neglected, or have reason to believe a child seen in the course of our professional duties has been threatened with abuse or neglect, and that abuse or neglect of the

child may occur, we must report this to the relevant county department, child welfare agency, police, or sheriff's department. If we believe that an elder or other at-risk adult has been or may be abused or neglected, we must report such information to the relevant county department or state official.

- **Serious Threat to Health or Safety** – If we have reason to believe, exercising professional care and skill, that you present a serious and imminent threat to the health and safety of you or the public, we must warn the third party and/or take steps to protect you or the public. This may include the disclosure of PHI to the necessary authorities. If you are experiencing a medical emergency, we may need to release information relevant to your safety. 45 CFR § 164.512(j).
- **Health Oversight Activities** – We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Notification and Communication with Family and Friends** - In recognition of the integral role that family and friends may play in your health care, the HIPAA Privacy Rule allows limited, and often critical, communications between health care providers and these persons.
 - If you are not able to tell us your preference about us communicating with your family & friends, for example, if you are unconscious, we may share your information if we believe, using professional judgement, it is in your best interest. We may also share your information when needed to lessen a serious or imminent threat to health or safety of you or the public.
 - If you have a legal power of attorney for healthcare or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has authority and can act for you before we take action.
 - *According to Wisconsin law, a patient's authorization is necessary in order for your health care provider to have such conversations with your family and friends. In an emergency, and in the absence of patient authorization, providers may use their professional judgement in determining whether to contact or share information with family members or friends involved in your care. (Wis. Stats. 51.30(4)(b)8).*
- **Business Associates** – We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, interpreting, or consulting services. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.
- **Workers' Compensation** – If you file a worker's compensation claim, we may be required to release records relevant to that claim to your employer, or its insurer, and may be required to testify.
- **Comply with the Law** – We may share your PHI if state or federal laws require it, including with the Department of Health and Human Services, if such agencies want to see that we're complying with federal privacy law.
- **Enforcement and other Essential Government Functions** - such as military, national security, and presidential protective services. We may disclose PHI about you when required to do so by international, federal, state, or local law.
 - *Wisconsin law generally requires patient consent for disclosures of PHI for law enforcement purposes, unless the disclosure is otherwise authorized or required by law, such as a judicial court order.*
- **Judicial and Administrative Proceedings** - If you are involved in a court proceeding and a request is made for information about your PHI, such information is privileged under state law and we will not release the information without written authorization from you or your personal or legally-appointed representative, a court order, or administrative tribunal. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered.
- **Court Orders and Subpoenas** – We may disclose PHI about you in response to a court or administrative order, or in response to a subpoena. Additional information regarding court orders and subpoenas can be found at: <https://www.hhs.gov/hipaa/for-individuals/court-orders-subpoenas/index.html>. Also see: Wis. Statute 908.03 (6)(m) (c).

- **Death notice** - We may disclose PHI to a coroner or medical examiner when a patient dies.
 - *Wisconsin law generally requires consent of a patient's authorized family or legal representative to release health information to other entities.*

IV. Uses and Disclosures That Require Us To Give You the Opportunity To Object & Opt Out

- **Fundraising, Marketing, or Research** - It is not the standard practice of our clinic to engage in fundraising or research. However, in the event we do, per 45 CFR Parts 160 & 164, we would not use your PHI without first giving you the opportunity to object and opt out.
- **Disaster Relief** - We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster.

V. Other Uses and Disclosures

Other uses and disclosures of PHI not covered by this Notice, or the laws that apply to use, will be made only with your written authorization. You may revoke your authorization at any time by submitting a written revocation to our records department. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy, or both, of PHI, as well as to direct us to transmit a copy to a designated person or entity of your choice. We require your request in writing (45 CFR 164.524 (b)(1)). We may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. You must direct us in writing to submit your PHI to a third party not covered in this notice. We may deny your request in certain limited circumstances.
- **Right to Electronic Copy of Electronic Medical Records** – If your PHI is maintained in an electronic format (known as electronic medical record or electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request, your record will be provided in a readable hard copy form. Per 45 CFR 164.524(c)(4), we reserve the right to charge a fee as allowable by law.
- **Right to Receive Notice of Breach** – As required by law, you have the right to receive notification if your health information is acquired, accessed, used, or disclosed in an unauthorized manner.
- **Right to Request Amendments** – If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment.
- **Right to Accounting of Disclosures** – You have the right to ask for an “accounting of disclosures,” which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing.
- **Right to Request Restrictions** – You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply, unless the information is needed to provide emergency treatment. We will honor your request to restrict disclosure of your PHI to your health plan for payment and healthcare operations purposes, and if not otherwise required by law, when you or someone on your behalf pays for your services in full. To request restrictions, you must make your request in writing to our office.
- **Right to Request Confidential Communications** – You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

- **Right to Paper Copy of This Notice** – You can ask for a paper copy of this notice at any time and it will be provided to you.
- **Complaints** - If you believe your privacy rights have been violated, you may file a complaint at the address listed below. If you have any questions about this notice or if you require additional information, please contact:

Eclipse Counseling
 Attn: Cory Tischman
 2004 Highland Ave, Suite O
 Eau Claire, WI 54701

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Secretary of the U.S. Department of Health and Human Services Office of Civil Rights. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201. Call (202) 619-0257, toll free (877) 696-6775, or go to the website of the Office for Civil Rights, or visit www.hhs.gov/ocr/privacy/hipaa/complaints/ for more information.

Your complaint will not affect the care and services we provide you in the present or future.

This Notice of Privacy Practices is effective 01/01/2021. We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information we maintain, regardless of when it was created or received. A copy of the current notice posted in our reception area. You are welcome to a copy of this notice at any time. A copy of this notice is also posted on our website.

For more information regarding HIPAA, you may go to: <https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html>

By signing, I hereby acknowledge that I have received and understand Eclipse Counseling’s Notice of HIPAA Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Cory Tischman, Clinical Director and HIPAA Compliance Officer, at Eclipse Counseling.

Client’s Name **Client’s Date of Birth (MM/DD/YYYY)**

Client’s Signature (if age 14 or older) **Date**

Signature of Legal Guardian **Date**

- If signed by a person other than the patient, complete the following:
1. Client is: Minor Incompetent Unable to sign due to disability
 2. Legal Authority: Custodial Parent Legal Guardian/Representative

Witnessed by Eclipse Counseling Representative **Date**