

ROGER D. CARLSON, PH.D., M.DIV., CST, SCEH ACE
LICENSED PSYCHOLOGIST
MAILING ADDRESS: 9450 S.W. 52ND AVENUE
PORTLAND, OREGON 97219
ROGERDCARLSON@GMAIL.COM
FAX 503-245-4478

NOTICE OF PRIVACY PRACTICES

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

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

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

- “PHI” refers to information in your health records that could identify you.
- “Treatment, Payment and Health Care Operations”
 - * *Treatment* is 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 of payment 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 care-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.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures.

In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization from you before releasing any psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If there is a child abuse investigation, I may be compelled to turn over your relevant records.
- **Adult and Domestic Abuse:** If there is an elder abuse or domestic violence investigation, I may be compelled to turn over your relevant records.
- **Health Oversight:** The Oregon State Board of Psychologist Examiners may subpoena relevant records from me should I be the subject of a complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis, and treatment, and the records thereof, such information is privileged under state law, and I must not release your information without written authorization by you or your personal or legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** I may disclose confidential information when I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. I must limit disclosure of the otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.
- **Worker's Compensation:** If you file a worker's compensation claim, this constitutes authorization for me to release your relevant mental health records to involved parties and officials. This would include a past history of complaints or treatment of a condition similar to that in the complaint.

IV. Patient's Rights and Psychologist's Duties

A. Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternate Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You general have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

A. Psychologist's Duties:

- I am required by law to maintain a 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 provide you with a notice of these changes either in person or by email.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me directly. 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.

VI. Effective Date, Restrictions and Changes to Privacy Policies

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If I do make such a change, I will provide you with a revised notice either in person or by mail.

ROGER D. CARLSON, PH.D., M.DIV., CST, SCEH ACE
LICENSED PSYCHOLOGIST

I have received and read the "Notice of Privacy Practices" for the psychology practice of Roger D. Carlson, Ph. D.

Signed _____ Date _____

Printed Name: _____

ROGER D. CARLSON, PH.D., M.DIV., CST, SCEH ACE
LICENSED PSYCHOLOGIST

I have received and read the "Notice of Privacy Practices" for the psychology practice of Roger D. Carlson, Ph. D.

Signed _____ Date _____

Printed Name: _____

ROGER D. CARLSON, PH.D., M.DIV., CST, SCEH ACE
LICENSED PSYCHOLOGIST

I have received and read the "Notice of Privacy Practices" for the psychology practice of Roger D. Carlson, Ph. D.

Signed _____ Date _____

Printed Name: _____