

Lianne O'Reilly Therapy

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Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by providing one to you at your next appointment or sending a copy to you in the mail upon request.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

FOR TREATMENT. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. These may include your Primary Care Physician and other health care professionals who are involved in your care. Your written authorization is not required only when your case is discussed in consultation with full anonymity. If any identifying information is used for consultation or collaboration with other care providers your written authorization is required.

FOR PAYMENT. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are; making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

FOR HEALTH CARE OPERATIONS. I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties who are contracted to remind you of your appointment, my answering service and other third parties that perform various business activities (e.g., billing, faxing, or typing services) provided I have a written contract with the contractor or business that requires it to safeguard the privacy of your PHI.

REQUIRED BY LAW. Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosure to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

Required by Law:

-Child Abuse: If I, in my professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, I must immediately report such a condition to the Massachusetts Department of Social Services.

-Adult and Domestic Abuse: If I have reasonable cause to believe that an elderly person (age 60 or older) is suffering as a result of abuse, I must immediately make a report to the Massachusetts Department of Elder Affairs.

-Required by Court Order: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative, or a court order. The 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 the case.

-Serious Threat to Health or Safety: If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you have history of physical violence and I believe there is clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment, and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment. In such a situation I may contact members of your family or other individuals if it would assist in protecting you.

-Worker's Compensation: If you file a worker's compensation claim your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

Verbal Permission. I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. When asked for information for purposes outside of treatment or require same from another entity, I will obtain written authorization from you first. I will also obtain an additional written authorization from you before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during each psychotherapy session. These notes are kept separate from the rest of your medical record as required by law. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization (of PHI or psychotherapy notes) at any time provided each revocation is in writing. You may not revoke an authorization to the extent that I have relied on that authorization, or if the authorization was obtained to obtain insurance coverage, or if the law provides the insurer the right to contest the claims under the policy.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to your therapist:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to make the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI for which you have neither provided consent nor authorization. I may charge you \$2.00 per page if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. I am not required, by federal regulation, to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you may request that I do not leave messages on your answering machine/voicemail or another person who answers the phone.

Right to a Copy of This Notice. You have the right to a copy of this notice. You may ask your therapist to give you a copy of this notice at any time.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with your therapist or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202)619-0257. **I will not retaliate against you for filing a complaint.**

I hereby acknowledge that I have received and been given an opportunity to read a copy of Notice of Privacy Practices for Lianne O'Reilly Therapy.