



**Transcend Wellness Center**  
www.transcendwellnesscenter.com  
Email: joanna@transcendwellnesscenter.com  
651-560-6407

## **NOTICE OF PRIVACY PRACTICES – HIPAA**

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.

### **My Pledge and Legal Duty to Protect Health Information about You.**

#### **How the law allows me to use and disclose your protected health information**

The U.S. Department of Health and Human Services (“HHS”) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The Privacy Rule standards address the use and disclosure of individuals’ health information—called “protected health information” by organizations subject to the Privacy Rule — called “covered entities,” as well as standards for individuals’ privacy rights to understand and control how their health information is used.

**My commitment to your privacy** I am required by federal and state laws to protect the privacy of your health information. I refer to this information as “protected health information,” or “PHI”. I must give you notice of our legal duties and a privacy practices concerning PHI, including:

- I must protect PHI that I have created or received about your past, present, or future health condition, health care I provide to you, or payment for your health care.
- I must notify you about how I protect PHI about you.
- I must explain how, when and why I use and/or disclose PHI about you.
- I may only use and/or disclose PHI as I have described in this Notice.
- I must abide by the terms of this Notice.

I am required to abide by the terms of this Notice. I reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that I maintain. I will post a revised notice in my office and make copies available to you upon request.

### **Minnesota Patient Consent for Disclosures**

For most disclosures of your health information I am required by State of Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law. This consent may be obtained at the beginning of your treatment, during the first delivery of health care service, or at a later point in your care, when the need arises to disclose your health information to others outside of our organization.



## Transcend Wellness Center

www.transcendwellnesscenter.com

Email: joanna@transcendwellnesscenter.com

651-560-6407

### **USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

#### **A. Uses and Disclosures of Your Protected Health Information for Purposes of Treatment, Payment and Health Care Operations.**

**Health Care Treatment** means providing, coordinating, or managing health care and related services by one or more health care therapists. An example of this would be releasing treatment session notes. I may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others. For example, I may use and disclose PHI about you when you need other health care services. In addition, I may use and disclose PHI about you when referring you to another health care provider.

**Payment** means such activities as billing or collection activities, and utilization review. I may use and disclose your medical information for billing purposes or to collect payment for the treatment and services provided to you. I may also share portions of your medical information with the following: 1) Collection agencies.

**Health Care Operations** include business aspects of running my therapy practice. An example of this would be confirming or canceling appointments. I may use and disclose PHI in performing business activities, which I call “health care operations”. For example: Members of our staff such as the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service I provide.

#### **B. Use And Disclosure Authorized by Law that Do Not Require Your Consent, Authorization or Opportunity to Agree or Object.**

Under certain circumstances I am authorized to use and disclose your health information without obtaining a consent or authorization from you or giving you the opportunity to agree or object. These include:

- When the use and/or disclosure is authorized or required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the use and/or disclosure is necessary for public health activities. For example, I may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect or domestic violence.



## Transcend Wellness Center

[www.transcendwellnesscenter.com](http://www.transcendwellnesscenter.com)

Email: [joanna@transcendwellnesscenter.com](mailto:joanna@transcendwellnesscenter.com)

651-560-6407

- When the use and/or disclosure is to avert a serious threat to health or safety. For example, I may disclose PHI about you to prevent or lessen a serious and eminent threat to the health or safety of a person or the public, or to yourself.
- When the use and/or disclosure is for health oversight activities. For example, I may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations.
- When the disclosure is for judicial and administrative proceedings. For example, I may disclose PHI about you in response to an order of a court or administrative tribunal.
- When the disclosure is for law enforcement purposes. For example, I may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure relates to decedents. For example, I may disclose PHI about you to a coroner or medical examiner, consistent with applicable laws, to carry out their duties.
- When the use and/or disclosure relates to Worker's Compensation information: I may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- When the use and/or disclosure relates to specialized government functions. For example, I may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, I may disclose PHI about you to a correctional institution having lawful custody of you.

## **YOUR INDIVIDUAL RIGHTS**

### **A. Right to Request Restrictions on Uses and Disclosures of PHI.**

You have the right to request that I restrict the use and disclosure of PHI about you. I am not required to agree to your requested restrictions. However, even if I agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and Duty To Warn. You may request a restriction by submitting your request in writing to us. I will notify you if I am unable to agree to your request.



## Transcend Wellness Center

[www.transcendwellnesscenter.com](http://www.transcendwellnesscenter.com)

Email: [joanna@transcendwellnesscenter.com](mailto:joanna@transcendwellnesscenter.com)

651-560-6407

### **B. Right to Request Communications via Alternative Means or to Alternative Locations.**

You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members, friends, or any person identified by you. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. Periodically, I will contact you by phone, email, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that I communicate with you through alternative means or to alternative locations. For example, you may request that I contact you at your work address or phone number or by email. While I am not required to agree with your request, I will make efforts to accommodate reasonable requests. You must submit your request in writing.

### **C. Right to See and Copy PHI.**

You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. I may charge you related fees. Instead of providing you with a full copy of the PHI, I may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which I am not required to comply with your request. Under these circumstances, I will respond to you in writing, stating why I will not grant your request.

### **D. Right to Request Amendment of PHI.**

You have the right to request that I make amendments to clinical, financial and other health-related information that I maintain and use to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment and, when appropriate, provide supporting documentation. I may deny your request.

### **E. Right to Request an Accounting of Disclosures of PHI.**

You have the right to a listing of certain disclosures I have made of your PHI. You must request this in writing. You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). If you request a list of disclosures more than once in 12 months, I can charge you a reasonable fee.



## Transcend Wellness Center

[www.transcendwellnesscenter.com](http://www.transcendwellnesscenter.com)

Email: [joanna@transcendwellnesscenter.com](mailto:joanna@transcendwellnesscenter.com)  
651-560-6407

### **F. Right to Receive a Copy of This Notice.**

You have the right to request and receive a paper copy of this Notice at any time. I am obligated to receive, a written acknowledgement that you have received a copy of my *Notice of Privacy Practices*.

### **QUESTIONS OR COMPLAINTS**

If you are concerned that I may have violated your privacy rights, you may file a complaint with me or with the U.S. Department of Health and Human Services. I support your right to the privacy of your health information, and will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

#### **Complaint Contact Information:**

JoAnna Smith, MA, LAMFT 4651 Nicols Rd, Suite 205 Eagan, MN 55122 651-560-6407

U.S. Department of Health & Human Services 200 Independence Avenue, S.W., Washington, D.C. 20201 Toll Free: 1-877-696-6775