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, and future physical or mental condition or condition and related health care services is referred to Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to 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 our 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 posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Without Your Authorization: Applicable law and ethical standards permit me to disclose information about you without your authorization only in limited situations. For each category of uses or disclosures I will explain what I mean and try to provide some examples. Not every use or disclosure in a category will be listed. However, all the ways I am permitted to use and disclose information will fall within one of the following categories.

A. **For Treatment:** Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing , coordinating, or managing your health care treatment and related services in my practice. For example, information obtained from a nurse, physician, or other members of your health care treatment team will be recorded in your record and used to determine the course of treatment for you. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant or healthcare provider only with your authorization.

B. **For Payment:** I may use and disclose PHI so that I can receive payment for you, an insurance company or third party, for services I have provided to you. For example, I may need to give your health plan information about treatment you received from our clinic so your health plan will pay me or reimburse you for the treatment. I may also tell your health plan about treatment you are going to receive in order to obtain prior approval for the service. The information disclosed will be limited in nature of the service provided, the dates of services, the amount due and other financial services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

C. **For Health Care Operations:** I may use or disclose your PHI for health care operations. These uses and disclosures are necessary to run my practice and make sure all my clients receive quality care. For example, I may use medical information to review my treatment and services and to evaluate the performance of my staff in caring for you. For employee training or teaching purposes PHI will be disclosed only with your authorization.

D. Judicial and Administrative Proceedings: In any judicial or administrative proceeding, you have the right to refuse to authorize the disclosure of any communication between you and a social worker relating to your care and treatment. There are few instances in which this privilege would not apply, and therefore, in which I could testify in the judicial or administrative proceeding. Specifically, I may disclose such communications during judicial or administrative proceedings, if (i) I determine that you need hospitalization or are a threat to yourself or to others; (ii) the communications were made in the course of a court-ordered psychiatric examination; (iii) you are a party to a case and you have introduced your mental or emotional state as an element of a claim or defense; (iv) if the testimony is given in connection with a care and protection proceeding, or a petition to dispense with parental consent to adoption; (v) in connection with any malpractice action brought by you against me, where disclosure is necessary for my defense; (vi) if the communications relate to your ability to provide care or custody in a child custody or adoption case; (vii) if the communication were made in connection with and during an investigation of allegations of child abuse, when I have made a report that I have reasonable cause to believe that child abuse is occurring; or (viii) if I believe a child, a disabled person, or an elderly person in your care is suffering abuse or neglect.

E. In an Emergency: I may disclose you PHI to a physician who requests such records in the treatment of a medical or psychiatric emergency. For example, if you are unconscious and the doctor treating you needs to know details regarding your medical history in order to decide a course of treatment for you, I would disclose the PHI necessary for the doctor to treat you during an emergency. If it is not possible to obtain your consent to this disclosure, then notice of the disclosure will be provided to you as soon as possible.

F. As Required by Law: I may disclose your PHI as required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigation.

G. If Required by Court Order: I may disclose your PHI in a judicial proceeding if required by a Court order.

H. If Necessary Because of Threat to Health and Safety: I may disclose your PHI if necessary to prevent or lesson a serious and imminent to the health or safety of a person or the public. I may disclose your present danger to yourself of others, if (1) you present a clear and present danger to yourself, or (2) you have communicated an explicit threat to kill or inflict serious bodily injury upon another person, and there is a basis for a reasonable belief that the threat may be carried out. If information is disclosed tp prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the treat.

I. Business Associates: Some services in our organization I obtain through contracts with business associates. For example, I may contract with outside companies to provide legal service, accounting services, or billing services. When I contract with a business associate, I may disclose health information to the business associate so it can do the job I've asked it to do. To protect your health information, I require the business associate to appropriately safeguard your health information.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization.

Revocation of Authorization. If you provide me with permission to use or disclose PHI about you, you may revoke that permission, in writing at any time. If you revoke your authorization, I will no longer use or disclose medical information about you for the purposes covered by the written authorization. However, I am unable to take back any disclosures that I have already made with you authorization.

YOUR RIGHTS REGARDING YOUR PHI

You, or your authorized representative, have the following rights regarding PHI that I maintain about you. To exercise any of these rights, please submit your request in writing to me at 11 High Street, #1 Milton, MA 02186.

- **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 be reasonably likely endanger the life or physical safety of you or another person. I may charge a reasonable, cost-based fee for copies. I will act on your request within 30 days of receiving your request.

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

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that I make of your PHI. The list of certain disclosures I have made of you PHI. This is a list of certain disclosures I have made of your PHI. To make this request, you should submit it in writing to me. I may charge you a reasonable fee if you request more than one accounting in a 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information I use or disclosure about you for treatment, payment, or healthcare operations. For example, you might request that particularly sensitive information (such as the existence of drug dependence) not be disclosed for any purpose. I am not required to agree to your request. To request restrictions, you must submit your request in writing to me. In your request, you must tell me (1) what information you want to limit, (2) whether you want to limit the use, disclosure, or both, and (3) to whom you want the limits to apply (for example, disclosures to your insurance carrier.)

- **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 can ask that I only contact you at work or by mail.

- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT ME AT 617-991-4162 AND/ OR 11 High Street, #1, Milton, MA 02186

We will not retaliate against you for filing a complaint.
The effective date of this Notice is March 1, 2010.

I _____ have received a copy of and understand this Notice of Privacy Practices.

x_____ _____/_____/_____
Signature Date

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name: _____

DOB: _____ / _____ / _____

SSN: _____ - _____ - _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Sherrad Barton LICSW, CADC II, LADC II Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Sherrad Barton at 11 High Street, #1, Milton, MA 02186 or 617-991-4162.

X _____ _____/_____/_____

Signature of Patient/Client Date

X _____ _____/_____/_____

Signature of Parent, Guardian, or Personal Representative* Date

*If you are signing as a personal representative of an individual, please document your legal authority to act for this individual (power of attorney, healthcare surrogate, ect.)

☐ Patient /Client Refuses to Acknowledge Receipt:

X_____

Sherrad Barton, LICSW, CADC II, LADC II