
Juliane Taylor Shore,
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# Privacy Notice

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 REVIEW THIS CAREFULLY.

Your privacy is of the utmost importance to me and the information I have about you will be held to the highest levels of confidentiality.

Health information includes any information related to your physical or mental health or condition, the health care provided to you, the payment for your health care, and individually identifiable information such as your name, address, or telephone number. When you receive services from me, I will obtain and/or create protected health information (PHI) about you. This notice tells you about my duty to protect your PHI and how I may disclose your health information.

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 Privacy Notice.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you a revised copy at your next visit or by mail.

**Uses and Disclosures for Treatment, Payment and Health Care Operations Requiring Your Advanced Consent:**

I may use or disclose your PHI for treatment, payment and health care operations purposes with your consent.

**Treatment:** I can use or disclose PHI to provide, coordinate, or manage health care or related services. This includes providing care to you, consulting with another health care provider about you, and referring you another health care provider.

**Payment**: I can use or disclose your PHI to obtain payment for providing health care to you or to provide benefits to you under a health plan.

**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, providing medical review, legal services, or auditing functions. For training or teaching purposes, PHI will be disclosed only with your authorization. I may use your PHI when leaving messages to follow-up on or confirm appointments, unless you have directed me not to do so.


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## Uses and Disclosures Requiring Neither Your Consent nor Authorization

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

*Child Abuse:* If I have cause to believe that a child has been or may be physically abused, neglected or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission or to any local or state law enforcement agency.

*Adult and Domestic Abuse:* If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect or exploitation, I must immediately report such to the Texas Department of Protective and Regulatory Services

*Abuse by a Therapist:* If I have cause to believe that you have been the victim of sexual exploitation by a mental health professional during the course of treatment, I will report this to the appropriate State Examining Board.

*Health Oversight:* If a complaint is filed against a therapist with the appropriate overseeing State Board they have the authority to subpoena confidential mental health information from the therapist relevant to that complaint.

*Judicial or Administrative Proceedings:* 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. Therefore, I will not release information without written authorization from you 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:* If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant PHI to medical or law enforcement personnel.

*Worker's Compensation:* If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

## Uses and Disclosures Requiring Your Specific Written Authorization

I may 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 general consent that permits only specific disclosures. In those instances, when I am asked for information outside of treatment, payment and health care operations, I will obtain written authorization from you before releasing this information. I will also need to obtain an authorization before releasing therapy notes. Therapy notes are notes I have made about our conversation during a private, group or joint counseling session. You may revoke all such authorizations (of PHI or therapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have 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 consent the claim under the policy.

## Your Rights

You have the following rights regarding health information I maintain about you:


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- *Right to Inspect and Copy*: You have the right to inspect and/or copy your health information, such as therapy notes and billing records. You must submit a written request to me in order to inspect and/or copy your information. If you request a copy of your information, I may charge you appropriate fees for copying, mailing or other associated supplies. I may deny your request to inspect and/or copy in certain limited 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, but will keep a record that you made such a request. I will discuss with you the details of the amendment process.
- *Right to Receive Confidential Communications by Alternative 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 that you are seeing me. Upon your request, I will send information to another address.)
- *Right to Accounting:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy:* You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

## Complaints

If you are concerned that your rights have been violated or you disagree with a decision made about access to your records, please talk to me about these concerns.

You may also file a complaint with the federal government. You may write to:

Office for Civil rights
US Department of Health and Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
email: ocrcomplaint@hhs.gov

You will not be penalized for filing a complaint with the federal government.

Acknowledgement of Privacy Notice(all adults attending, please sign): ***I hereby acknowledge that I have received the Notice of Privacy Practices for Juliane Taylor Shore, LPC, LMFT, SEP.***

Signature:_____ Date:_____

Printed Name:_____

Signature:_____ Date:_____

Printed Name:_____