

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOU MAY HAVE ADDITIONAL RIGHTS UNDER STATE AND LOCAL LAW. PLEASE SEEK LEGAL COUNSEL FROM AN ATTORNEY LICENSED IN YOUR STATE IF YOU HAVE QUESTIONS REGARDING YOUR RIGHTS TO HEALTH CARE INFORMATION.

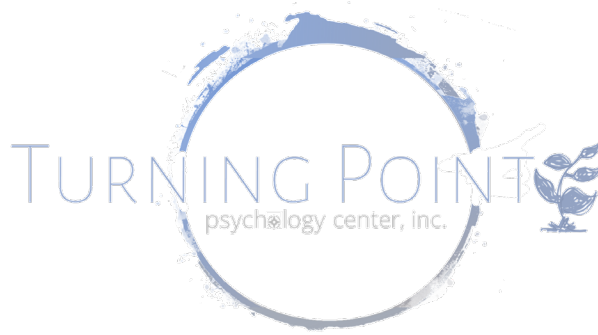
Under the Health Insurance Portability and Accountability Act of 1996 (hereafter, "HIPAA"), you have certain rights regarding the use and disclosure of your Protected Health Information (hereafter, "PHI"). This Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic data, that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the past, present, or future payment for the provision of health care to you, and that identifies you or for which there is a reasonable basis to believe can be used to identify you. Individually identifiable health information includes many common identifiers (e.g. name, address, birthdate, Social Security Number.)

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information.

I am required by law to:

- Make sure that PHI that identifies you is kept private and disclosed only with your written authorization, unless needed for treatment, payment, health care operations, or otherwise permitted or required by law.
- Give you this notice of my legal duties and privacy practices with respect to your health information.
- Follow the terms of the notice that is currently in effect.
- Notify you following a breach of unsecured PHI



- I can change the terms of this Notice and such changes will apply to all the information I have about you. If any revisions are made to this Notice, the new Notice will be posted on my website, posted in my office, and available upon request.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment, Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. Examples of Health Care Operations are sending you appointment reminders, billing invoices and other documentation; quality assessments and improvement activities, including case management and care coordination; competency assurance activities, audits, business planning, development, management and general administrative activities, including, but not limited to, de-identifying PHI. Examples of payment encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, furnish or obtain reimbursement for health care delivered to you, and my activities to obtain payment or be reimbursed for the providing of health care to you.

I may also disclose your PHI for the treatment activities to other health care providers. This, too, can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your PHI, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your health condition. It is my practice to make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure, or request. However, disclosures for *treatment purposes* are not limited to the minimum necessary standard because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: In response to an order of a court or administrative tribunal, I may disclose your health information, but only the PHI expressly authorized by such order. In response to a request of your PHI to a subpoena, discovery request, or other lawful process in a judicial or administrative proceeding that is not accompanied by an order of a court or administrative



tribunal, I will not release the records unless I have received satisfactory assurance that the party seeking your information has given you notice of the request and allowed you time to object; or that the requesting party has made reasonable efforts to secure a qualified protective order that prohibits the parties from using or disclosing your PHI for any purpose other than the litigation or proceeding for which such information was requested; that the protective order requires the return to my office or the destruction of the PHI (including all copies made) at the end of the litigation or proceeding; and that no objections were filed by you or if any objections were raised by you, they have been resolved. In addition, I will make reasonable efforts to notify you upon receipt of any of these requests.

Incidental Use and Disclosure:

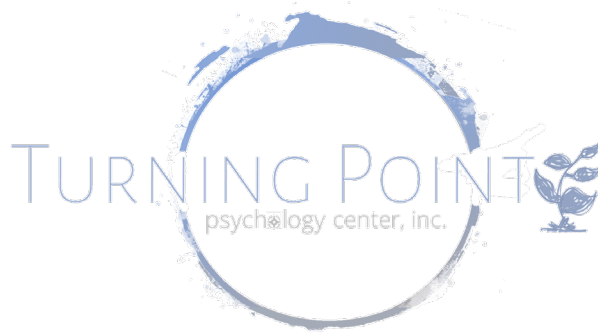
Not every risk of an incidental use or disclosure of your PHI can be eliminated. A use or disclosure of PHI that occurs as a result of, or as “incident to,” an otherwise permitted use or disclosure is permitted as long as I have taken reasonable safeguards, as required by law, and the information being shared was limited to the “minimum necessary,” as required by law.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

Psychotherapy Notes. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your separate Authorization unless the use or disclosure is:

- a. For my use in treating you.
- b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
- c. For my use in defending myself in legal proceedings instituted by you.
- d. For use by the Secretary of the Department of Health and Human Services (HHS) to investigate my compliance with HIPAA.
- e. Required by law and the use or disclosure is limited to the requirements of such law.
- f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
- g. Required by a coroner who is performing duties authorized by law.
- h. Required to help avert a serious threat to the health and safety of others.

Marketing Purposes. I will not use or disclose your PHI for marketing purposes without your prior written consent. For example, if I request a review from you and plan to share the review publically online or elsewhere to advertise my services or my practice, I will provide you with a release form and HIPAA authorization. The HIPAA authorization is required in the instance that



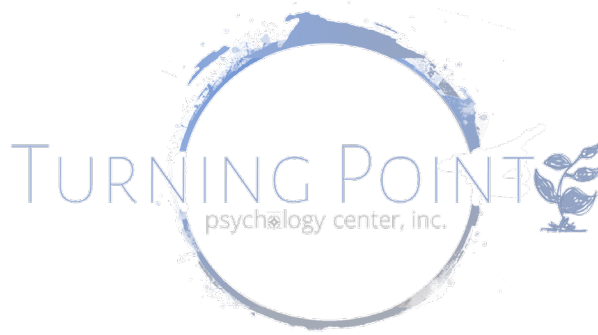
your review contains PHI (i.e., your name, the date of the service you received, the kind of treatment you are seeking or other personal health details). Because you may not realize which information you provide is considered “PHI,” I will send you a HIPAA authorization and request your signature regardless of the content of your review. Once you complete the HIPAA authorization, I will have the legal right to use your review for advertising and marketing purposes, even if it contains PHI. You may withdraw this consent at any time by submitting a written request to me via the email address I keep on file or via certified mail to my address. Once I have received your written withdrawal of consent, I will remove your review from my website and from any other places where I have posted it. I cannot guarantee that others who may have copied your review from my website or from other locations will also remove the review. This is a risk that I want you to be aware of, should you give me permission to post your review.

Sale of PHI. I will not sell your PHI.

IV. USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons. I have to meet certain legal conditions before I can share your information for these purposes:

1. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.
2. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
3. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
4. For health oversight activities, including audits and investigations.
5. Responding to a court or administrative order or in response to lawsuits and disputes as explained above.
6. If necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
7. For law enforcement purposes, including reporting crimes occurring on my premises.
8. To coroners, medical examiners, and funeral directors when such individuals are performing duties authorized by law.
9. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.



10. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; National Instant Criminal Background Check system for the identity of an individual who is prohibited from possessing a firearm; or, helping to ensure the safety of those working within or housed in correctional institutions.
11. A health plan that is a government program providing public benefits to you.
12. Workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
13. For organ and tissue donation requests.

V. REQUIRED DISCLOSURES.

Pursuant to 45 CFR §164.502(a)(1), I am *required* to disclose your PHI under two circumstances:

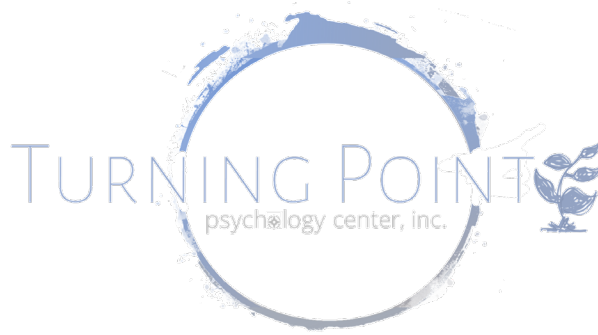
1. When requested by you (or your personal representative) specifically when you request access to, or an accounting of, disclosures of your PHI, except for some limited exceptions;
2. When required by the Health and Human Services Agency (HHS) when it is undertaking a compliance investigation or review or enforcement.

VI. PERMISSION TO DISCLOSE YOUR PHI TO NAMED INDIVIDUALS

Disclosures to family, friends, or others: You have the right and choice to tell me that I may provide your PHI to a family member, friend, attorney, or other person whom you indicate is involved in your care or the payment for your health care, or to share your information in a disaster relief situation. The opportunity to consent may be obtained retroactively in emergency situations to mitigate a serious and immediate threat to health or safety or if you are unconscious.

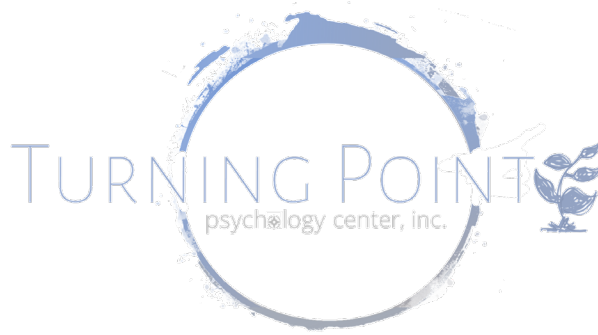
VII. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on the disclosure of your PHI to health plans for payment



or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and/or Get Copies of Your PHI. Other than in limited circumstances, you have the right to get an electronic or paper copy of your medical record and other information that I have about you. Ask us how to do this. I will provide you with a copy of your record, within 15 days of receiving your written request, or if you agree, a summary of it, available within 10 days. I may charge a reasonable fee for this request.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, and other disclosures (such as any you ask me to make). Ask me how to do this. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.
8. The Right to Choose Someone to Act For You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can make choices about your health information.
9. The Right to Revoke an Authorization.
10. The Right to Opt out of Communications and Fundraising from our Organization.
11. The Right to File a Complaint. You can file a complaint if you feel I have violated your rights by contacting me using the information on page one or by filing a complaint with the HHS Office for Civil Rights located at 200 Independence Avenue, S.W., Washington D.C. 20201, or calling HHS at (877) 696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you for filing a complaint.



III. CHANGES TO THIS NOTICE

I can change the terms of this Notice, and such changes will apply to all the information I have about you. The new Notice will be available upon request, in my office and on my website.
EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 29, 2021.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I ACKNOWLEDGE RECEIPT OF TURNING POINT'S PRIVACY NOTICE

CLIENT NAME: _____ **CLIENT DOB:** _____

Signature of Client: _____ **Date:** _____

Signature of Parent/Guardian: _____ Date: _____

Relationship to Client: _____

Clinician Name: _____