

# NOTICE OF PRIVACY PRACTICES

(This office requires your signature on the last page. If you are reading this online, please print the last page, sign and bring with you to your initial appt.)

**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.**

If you should have any questions about this Notice, please contact:

Shelly King at 512-804-2343.

## WHO WILL FOLLOW THIS NOTICE?

- ✓ James Ochoa (“Therapist”).
- ✓ All Therapist’s employees.

We understand that medical information about you and your health is personal, and we are committed to protecting this information. Each time you visit James Ochoa, a record of the care and services you receive is made. Typically, this record contains your symptoms, examination, diagnoses, psychotherapy notes, treatment, plan for future care or treatment, and billing record. This record serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health care professionals who contribute to your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Tool for educating health professionals;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice applies to all of the records of your care generated by Therapist.

This Notice will tell you about the ways we may use and disclose medical information about you. It also describes your rights and our obligations regarding the use and disclosure of medical information.

**The Life Empowerment Center**  
**James Ochoa, LPC, Inc.**

2111 Dickson Drive, Suite 14, Austin, TX, 78704  
phone: 512-804-2343 ❖ fax: 512-804-2300 ❖ web: www.tlec.info

## **OUR RESPONSIBILITIES.**

Therapist shall:

- Make every effort to maintain the privacy of your health information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

## **THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

The following categories describe different ways we may use and disclose your Protected Health Information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for treatment purposes.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you or a third party. While we do not bill insurance companies for services provided, we may provide information to your health insurance if questions arise about the treatment you received from us.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run Therapist's office in an efficient manner and ensure that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of health care services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, Therapist or any of his employees may provide a written or telephone reminder that your next appointment with Therapist or another therapist is coming up.

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- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another medication for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Therapist Sale of Practice.** We may use and disclose medical information about you to another therapist or healthcare facility in the sale, transfer, merger, or consolidation of Therapist's practice.

#### **SPECIAL SITUATIONS.**

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information or for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the research, audit, or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - To prevent or control disease, injury, or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

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- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court order or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - If Therapist determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.*, to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.

### **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.**

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. Your written authorization is required to receive a copy of your psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Therapist. If you request a copy of the information, Therapist or any of his employees may charge a fee established by the Texas Board of Medical Examiners for the costs of copying, mailing, or summarizing your medical records.

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Therapist or any of his employees may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, including psychotherapy notes, you may request that the denial be reviewed. Another licensed health care professional chosen by Therapist will review your request and denial. The person conducting the review will not be the person who denied your request. Therapist and his employees will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask Therapist or any of his employees to amend the information. You have the right to request an amendment for as long as the information is kept by Therapist or any of his employees.

To request an amendment, your request must be made in writing and submitted to Therapist. In addition, you must provide a reason that supports your request.

Therapist may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, Therapist may deny your request if you ask us to amend information that:

- Was not created by Therapist, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Therapist;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

To request this list you must submit your request in writing to Therapist. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Therapist will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Therapist uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Therapist discloses about you to someone who is involved in your care or the payment for your care.

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***Therapist is not required to agree to your request.*** Should Therapist agree to your request, Therapist will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions you must make your request in writing to Therapist. In your request you may indicate: (1) what information you want to limit; (2) whether you want to limit Therapist's use and/or disclosure; and (3) to whom you want the limits to apply. For example, you may not want disclosures to be made to your spouse.

- **Right to Request Confidential Communications.** You have the right to request that Therapist communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Therapist contact you only at work or by mail.

To request that Therapist communicate in a certain manner, you must make your request in writing to Therapist. You do not have to state a reason for your request. Therapist will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

### **CHANGES TO THIS NOTICE.**

We reserve the right to change our practices and to make the new provisions effective for all Protected Health Information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting Therapist.

### **COMPLAINTS.**

If you believe your privacy rights have been violated, you may file a complaint with your therapist or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with your therapist, contact Therapist at 512-804-2343. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Regional Office of Civil Rights is:

*Region VI, Office of Civil Rights  
U.S. Department of Health and Human Services  
1301 Young Street, Suite 1169  
Dallas, Texas 75202*

The address for the office of James Ochoa is:

*2111 Dickson Street, Suite 14  
Austin, Texas 78704*

All complaints should be submitted in writing.

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*You will NOT be penalized for filing a complaint.*

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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**I acknowledge that Therapist provided me with a written copy of his Notice of Privacy Practices.**

**I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal Representative Signature (if applicable)

\_\_\_\_\_  
Relationship to Patient