

Roopa Baruah, LCSW, CCHt.

## **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this Notice of Privacy Practices, please contact, Roopa Baruah, LCSW, CCHt.

### **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 protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to PHI.
- Notify you following a breach of unsecured PHI.
- Follow the terms of the notice that is currently in effect.

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

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

The following categories describe different ways that I use and disclose PHI. For each category of uses or disclosures I will explain what I mean and try to give some examples. 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.** I may use or disclose your health information to provide and coordinate the mental health treatment and services you receive. For example, if your mental

health care needs to be coordinated with the medical care provided to you by another physician, I may disclose your health information to a physician or other healthcare provider. 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.

**For Payment.** I may use and disclose your health information for various payment-related functions, so that I can bill for and obtain payment for the treatment and services I provide for you. For example, your PHI may be provided to an insurance company so that they will pay claims for your care.

**For Healthcare Operations.** I may use and disclose your health information for certain operational, administrative, and quality assurance activities, in connection with our healthcare operations. These uses and disclosures are necessary to run the practice and to make sure that my clients receive quality treatment and services. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

### **III. CERTAIN USES AND PHI DISCLOSURES REQUIRE YOUR AUTHORIZATION**

1. **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 Authorization unless the use or disclosure is:

- For my use in treating you.
- 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.
- For my use in defending myself in legal proceedings instituted by you.
- For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
- Required by law and the use or disclosure is limited to the requirements of such law.

- Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
  - Required by a coroner who is performing duties authorized by law.
  - Required to help avert a serious threat to the health and safety of others.
2. **Marketing Purposes.** As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
  3. **Sale of PHI.** As a psychotherapist, I will not sell your PHI in the regular course of my business.

#### **IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION**

I am permitted under federal and applicable state law to use or disclose your PHI without your permission only when certain circumstances may arise. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. **Individuals Involved in Your Care or Payment for your Care.** I may disclose PHI to a close friend or family member who is involved in your medical care or payment for your care.
2. **Disclosures to Parents or Legal Guardians.** If you are a minor, I may release your PHI to your parents or legal guardians when I am permitted or required under federal and applicable state laws.
3. **Workers Compensation.** I may disclose your PHI to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law.
4. **Public Health.** I may disclose your PHI to federal, state, or local authorities, or other entities charged with preventing or controlling disease, injury, or disability for public health activities.
5. **Health Oversight Activities.** I may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for my licensure and for government monitoring of the health care system, government programs, and compliance with federal and applicable state laws.
6. **Judicial and Administrative Proceedings.** If you are involved in a lawsuit or legal dispute, I may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
7. **Law Enforcement.** I may disclose your PHI for law enforcement purposes as required by law or in response to a court order, subpoena, warrant, summons, or

similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about a death resulting from criminal conduct; about crimes on the premises or against a member of my workforce; and in emergency circumstances, to report a crime, the location, victims, or the identity, description, or location of the perpetrator of a crime.

8. **United States Department of Health and Human Services.** Under federal law, I am required to disclose your PHI to the U.S. Department of Health and Human Services to determine if I am in compliance with federal laws and regulations regarding the privacy of health information.
9. **Research.** Under certain circumstances, I may use or disclose your PHI for research purposes. However, before disclosing your PHI, the research project must be approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
10. **Coroners, medical examiners, funeral directors.** I may release your PHI to assist in identifying a deceased person or determine a cause of death.
11. **Organ or tissue procurement organizations.** Consistent with applicable laws, I may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
12. **Notification.** I may use or disclose your PHI to assist in a disaster relief effort so that your family, personal representative, or friends may be notified about your condition, status, and location.
13. **Correctional Institution.** If you are or become an inmate of a correctional institution, I may disclose to the institution or its agents PHI necessary for your health and the health and safety of others.
14. **To Avert Serious Threat to Health or Safety.** I may use or disclose your PHI to appropriate authorities when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. I may disclose health information to appropriate authorities I reasonably believe that you are a possible victim of abuse or neglect or the possible victim of other crimes.
15. **Military and Veterans.** If you are a member of the armed forces, I may release your PHI as required by military command authorities. I may also release PHI about foreign military personnel to the appropriate military authority.
16. **National Security, Intelligence Activities and Protected Services for the President and Others.** I may disclose your PHI to authorized federal officials for intelligence, counterintelligence, provision of protection to the President, other authorized

persons or foreign heads of state, and other national security activities authorized by law.

17. **As required by Law.** I must disclose your PHI when required to do so by applicable federal or state laws.
18. **Treatment Alternatives.** I may use and disclose PHI to tell you about or recommend possible alternative treatments, therapies, healthcare providers, or settings of care that may be of interest to you.
19. **Health related benefits and services.** I may also use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
20. **Appointment Reminders.** I may use and disclose your PHI to contact you to remind you that you have an appointment with me. You have a right, as explained below, to request restrictions or limitations on the PHI I disclose. You also have a right, as explained below, to request that information to be communicated with you in a certain way or at a certain location.

V. **CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.**

1. Disclosures to family, friends, or others. I may provide your PHI to a member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. **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 disclosures 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 Get Copies of Your PHI.** Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your

record, or a summary of it, if you agree to receive a summary, within 15 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

In accordance to Texas law, you have the right to obtain a copy of your PHI in electronic form for records that we maintain using an Electronic Health Records (EHR) system capable of fulfilling the request. Where applicable, I must provide those records to you or your legally authorized representative in electronic form within 15 days of receipt of your written request and a valid authorization for electronic disclosure of PHI.

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, or for which you provided me with an Authorization. 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 e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.
8. **The Right to Notification in the Event of a Breach.** You have a right to be notified of an impermissible use or disclosure that compromises the security or privacy of your PHI. I will provide notice to you as soon as is reasonably possible and no later than 60 calendar days after discovery of the breach and in accordance with federal and state law.
9. **The Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint to me. You may also file a complaint directly with any or all of the following federal and state agencies: the Secretary of the Department of Health and Human Services, the Office of Attorney General of Texas, or The Texas State Board of Social Worker Examiners. I will provide you

with the addresses to file your complaint with the Secretary, The Office of the Attorney General of Texas, and the Texas State Board of Social Worker Examiners, upon request. You will not be penalized in any way for filing a complaint. However, our ethical code may require me to terminate therapy with you and refer you to other providers if you file a complaint with one of the listed entities.

If you want more information about my privacy practices or have questions and concerns, please contact me.

Roopa Baruah, LCSW, CCHt.  
12440 Emily Court, Suite 801  
Sugar Land, TX 77478  
Telephone: (832) 654-3913  
E-mail: [info@roopabaruahtherapy.com](mailto:info@roopabaruahtherapy.com)

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Client Name: \_\_\_\_\_

**EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on \_\_\_\_\_

I have been given a copy of Roopa Baruah, LCSW, CCHt’s notice of privacy practices (“Notice”), which describes how my health information is used and shared. I understand that Ms. Baruah has a right to change this Notice at any time. I may obtain a current copy by contacting Ms. Baruah, who is the Privacy Officer, or by visiting Ms. Baruah’s website at:

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

**My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practice.**

\_\_\_\_\_  
Client Signature or Personal Representative

\_\_\_\_\_  
Print Name

Personal Representative’s Title: \_\_\_\_\_  
(e.g. guardian, executor of estate, healthcare power of attorney)

**For office use only: Complete this section if you were unable to obtain a signature.**

If client or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

---

Describe the steps taken to obtain the client's or personal representative's signature on the Acknowledgement:

---

---

Completed by:

---

Signature of Practice Representative

---

Date

---

Printed Name