**Nicole Castiglioni, LPC**

2264 Silas Deane Highway, Suite 300

Rocky Hill, CT 06067

860.301.0196

**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 it carefully and ask any questions you may have.

I care about my patients’ privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that healthcare providers issue this official notice of privacy practices. You have the right to confidentiality of your medical information, and I am required by law to maintain this privacy. This notice will apply to any healthcare personnel in this office who is authorized to enter information into your medical record or review these records for the purpose of your treatment.

**Understanding Your Protected Health Information (PHI)**

When you attend each session with me, a record is made of your symptoms, assessments, diagnoses, treatment plan, and other mental health or substance abuse information. Your record is the physical property of this practice, but the information within the record belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing me to release or disclose this information to others. In using and disclosing your protected health information (PHI), it is my objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act (HIPAA) as well as the requirements within the state of Connecticut. We may use and, at times, disclose protected health information about you in order to treat you effectively, properly and safely.

**Your mental health/substance abuse/medical record serves as:**

A basis for planning your treatment and care.

A means of communication among the various health professionals who are involved in your care.

A legal document describing the care that you received.

A means by which you, or a third-party payer, can verify that services billed were actually provided.

A source of information for public health officials charged with improving the health of the nation.

A source of data for facility planning.

A tool with which I can assess and continually work to improve the care that I render and the outcomes I achieve.

**Responsibilities of Nicole Castiglioni, LPC**

As part of HIPAA, I am required to maintain the privacy of your protected health information (PHI) and provide you with notice of my legal duties/privacy practices with respect to the protected health information that I collect and maintain about you. I am also required to abide by the terms of this notice currently in effect. I have the right to change the notice of privacy practices and to make the new provisions effective for all protected health information that I maintain. This includes any information that was obtained prior to any changes. Should any of the information management practices change, I will provide you with a copy. I am also required to notify you if I am unable to agree to a requested action; and I can only use or disclose your health information with your authorization, except as outlined in this notice.

**Your Protected Health Information (PHI) Rights**

You have the right to review and obtain a paper copy of this Notice of Privacy Practices upon request. You also have the right to see the protected health information within your medical record, with the exception of psychotherapy notes which are under special protection. I also reserve the right to not release your records to you should I feel that seeing this information might cause you significant damage. If I do release records to you, copy charges may apply. You have a right to request and provide written authorization and permission to release information for purposes of outside treatment and healthcare operations. This authorization excludes psychotherapy notes. You have the right to revoke your authorization in writing at any time to use, disclose or restrict health information except to the extent that action has already been taken. You have a right to request a restriction on certain uses and disclosures of protected health information, but I am not required to agree to the restriction request. You should address your restriction request in writing; I will notify you within 14 days if I cannot agree to the restriction. You have the right to request that I amend your health information by submitting a written request with the reasons support the request. Again; I am not required to agree to the requested amendment. You also have the right to obtain an account of disclosures of your health information for purposes other than treatment, payment and healthcare operations.

**Disclosures for Treatment, Payment and Healthcare Operations**

I will use your Protected Health Information, with your consent, in the following circumstances: **Treatment**; information obtained by your therapist will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you. **For payment**, if applicable; the information on, or accompanying, the bill that I generate to you and your insurance company may include information that identifies you, as well as your diagnosis, to obtain reimbursement for your healthcare or to determine eligibility or coverage. **For healthcare operations**; I may use information in your health record to assess the performance and operations of my services. This information will then be used in an effort to continually improve the quality and effectiveness of the mental health care and services I provide. **Disclosure to others outside of my own private practice**; if you give me written permission to speak with someone outside of my practice, this will allow me to communicate with this party. You may revoke the authorization by requesting a revocation in writing at any time. Please be aware that this request for revocation will exempt any disclosures permitted prior to the revocation request. I will not use or disclose your protected health information without your authorization, except as described below:

I will only disclose your Protected Health Information (PHI) without your consent or authorization under the following circumstances: **Child abuse**; if I have reasonable cause to suspect that a child known to me in the course of professional duties has been abused or neglected in any way, or if I have reason to believe that a child known to me in the course of professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, I must report this to the relevant child protection agency and the police. **Adult and Domestic abuse**; if I believe that a vulnerable adult (ex. incapacitated or facility resident) is the victim of abuse, neglect or domestic violence, or the possible victim of other crimes, I may report such information to the appropriate agency. **Serious threat to health or safety**; if I have reason to believe, exercising best judgment and my professional care and skill, that you may cause serious harm to yourself or another person, I may take steps, without your consent, to notify or assist in notifying a family member, personal representative, or another person responsible for your care. This might include information about your protected healthcare information, your location, your mental status and general condition. I would do this in order to protect you or another person from being harmed by you. This may include instituting commitment proceedings. **Judicial and administrative proceedings**; if you are involved in a court proceeding and a request if made for information about your diagnosis and treatment, and the records thereof, such information is privileged under state law and I will not release the information without written authorization from you or your personal or legally appointed representative, or a subpoena/court order. This privilege does not apply when you are being evaluated by a third-party or when the evaluation is court-ordered. **As required by law for national security and law enforcement**; I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. I may disclose health information for law enforcement purposes as required by law or in response to a valid court order. **Law/Health oversight**; as required by law, I may disclose your health information for health oversight purposes. For example, if the Connecticut Department of Public Health requests that I release records to them in order to investigate a complaint against a provider; I must comply with such a request. **Worker's Compensation**; I may disclose health information to the extent authorized by you, and to the extent necessary to comply with laws relating to worker's compensation or other similar program established by law. In some of these cases I may be needed to testify and your protected health information may be disclosed under these circumstances. **As required by law for purposes of public health**; e.g., as required by law, I may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. **Business associates**; there are some services provided to other entities through contracts with business associates. Examples include computer support for operations systems. When these services are contracted, I may disclose your health information to my business associate so that they can perform the job that they have been hired to do. Under these circumstances, any contracted associate is then also required to safeguard your protected health information.

**For more information or to report a problem**

If you have questions and would like additional information about your rights under the Health Information Portability and Accountability Act (HIPAA), please ask me directly and I will provide with as much additional information as I can. If there are questions that I cannot answer, I ask that you visit the US Department of Health and Human Services website listed below. If you are concerned that your privacy rights have been violated, or if you disagreed with a decision that I have made about access to your protected health information, I ask that you contact me directly to address this matter. If you feel your privacy rights have been violated, and you would like to file a complaint, you can do so with the Secretary of the U.S. Department of Health and Human Services. Here is their address:

U.S. Department of Health and Human Services

Office for Civil Rights

150 South Independence Mall West – Suite 372

Philadelphia, PA 19106-3499

Phone: (215) 861-4441; or TDD (215) 861-4440; Fax (215) 861-4431

<http://www.hhs/gov/ocr/privacyhowtofile.htm>

I respect your right to the privacy of your health information. There will be no retaliation for filing a complaint as outlined above.