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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.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on 11/6/2021.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

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").

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. Confidential health information includes all individually identifiable information, whether in electronic or physical form, that is in my possession or is derived from information you share in confidence with me regarding your medical or mental health history, a mental or physical condition, or mental or physical health treatment. 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.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- 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 the information I have about you. The new Notice will be available upon request, in my office, and on my website, dreliseyoshida.com.

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

The following categories describe different ways that I use and disclose health information. 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.

Treatment: I may use and disclose your health information to provide, coordinate or manage your health care and any related services. For example, information obtained from me or a member of my staff will be recorded in your record and used to determine the course of treatment for you. This includes consultation with other treatment team members. I may communicate information to another health care provider or third party for the purposes of coordinating your continuing care and may make that information available electronically. I will request authorization from you in writing before I disclose your health information to another provider or third party.

Payment: I may use and disclose your health information to bill for services provided and to obtain payment from you, an insurance company, a third party or a collection agency. This may include the disclosure of health information to obtain prior authorization for treatment and procedures from your insurance plan. The information disclosed will be limited to the nature of the services provided, the dates of services, the amount due and other relevant financial information.

For Health Care Operations: I may use or disclose your health information for health care operations. These uses and disclosures are necessary to run my practice and make sure that all of my clients receive quality care.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about you or your minor child(ren) in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Other disclosures: For example, your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that we try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

III. CERTAIN USES AND 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:
 - 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.
2. **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. If I believe that you are threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you.
5. If I have reason to believe that you present a danger to yourself, I am required to take protective actions. If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide you with protection;
6. For health oversight activities, including audits and investigations.
7. For judicial and administrative proceedings that are initiated by or brought against you, including responding to a court or administrative order or subpoena, although my preference is to obtain an Authorization from you before doing so if I am so allowed by the court or administrative officials.
8. For law enforcement purposes, including reporting crimes occurring on my premises.
9. To coroners or medical examiners, when such individuals are performing duties authorized by law.
10. 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.
11. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
12. For 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. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

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, or other person whom you indicate is involved in your care or the payment for your health care, or to share you 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.

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 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 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. Your request for inspection or copies, including electronic copies, must be in writing. A reasonable fee for copies will be charged. I may deny your request under very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed by another health care professional of your choosing.
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. I will not retaliate against you for filing a complaint. You can file a complaint by contacting me using the information on page one or by filing a complaint by visiting www.hhs.gov/ocr/privacy/hipaa/complaints or writing to:

Office for Civil Rights, Region IX
U.S. Department of Health and Human Services
50 United Nations Plaza, Room 322
San Francisco, CA 94102
Voice Phone (415) 437-8310
Fax (415) 437-8329
TDD (415) 437-8311

VII. 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, dreliseyoshida.com.