282 E Main Street
Newark, DE 19711

Phone : 443-987-6557
Fax : 410-793-1599
www.hoperisinghs.com

Hope Rising
Health Services, LLC

Notice of Privacy Practices

Rev. 9/2018

This notice involves your privacy rights and describes how information about you may be disclosed, and how you can obtain access to this information. Please review it carefully.

I. Confidentiality: Uses and Disclosures of Information Requiring Your Authorization or Consent

As a rule, we will disclose no information about you, or the fact that you are our patient, without your written consent. Our formal Mental Health Record describes the services provided to you and contains the dates of our sessions, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, we do not routinely disclose information in such circumstances, so we will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. Limits of Confidentiality: Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality. If you wish to receive mental health services from us, you must sign the attached form indicating that you understand and consent to accept my policies about confidentiality and its limits. We will discuss these issues at your first session, but you may reopen the conversation at any time during our work together. We may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- Emergency: If you are involved in what we consider to be a life-threatening emergency (including serious suicidal intent) and we cannot ask your permission, we will share information if we believe you would have wanted us to do so, or if we believe it will be helpful to you.
- Child Abuse Reporting: If we have reason to suspect that a child has been abused or neglected, we are required by Maryland and Delaware law to report the matter immediately to the Maryland and Delaware Child Protective Services, respectively. We will in most circumstances inform you of this before making a report.
- Adult Abuse Reporting: If we have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, we are required by Maryland and Delaware law to immediately make a report and provide relevant information to the Maryland and Delaware Adult Protective Services or Developmental Disabilities Administration, respectively. We will in most circumstances inform you of this before making a report.
- Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information unless you provide written authorization or a judge issues a court order/subpoena.
- Serious Threat to Health or Safety: Under Maryland and Delaware law, if you communicate to us a specific and immediate threat to cause serious bodily injury or

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- death to an identified or identifiable person, and we believe you have the intent and ability to carry out that threat imminently, we are legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. We may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

Other uses and disclosures of information not covered by this notice or by the laws that apply to us will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. If you ask us to disclose information to another party, you may request that we limit the information we disclose. However, we are not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell us: 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to receive confidential communications of Protected Health Information by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send correspondence to another address. You may also request that we contact you only at work, or that we do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how you wish to be contacted.
- Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of Protected Health Information for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, we will discuss with you the details of the accounting process
- Right to Review: In most cases, you have the right to inspect your medical and billing records. To do this, you must submit your request in writing. We generally do not provide copies of records, but can supply a treatment summary as outlined in the Informed Consent policy.
- Right to Amend: If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing, and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request if you ask us to amend information that: 1) was not created by us; 2) is not part of the medical information kept by us; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
- Right to a copy of this notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Changes to this notice: We reserve the right to change our policies and/or to change this notice, and to make the changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. We will have copies of the current notice available on request.

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Complaints: If you believe your privacy rights have been violated, you may file a complaint. Procedures for filing complaints can be found at http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html or by contacting our OCR regional office:
Region III - Philadelphia (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia)
Office for Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
Main Line (215)861-4441
Hotline (800) 368-1019
FAX (215)861-4431
TDD (215)861-4440

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Patient's Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgment form.

I _____, have been provided a copy of Hope Rising Health Services, LLC's "Notice of Privacy Practices."

We have discussed these policies, and I understand that I may ask questions about them at any time in the future. Furthermore, I consent to accept these policies as a condition of receiving mental health services at Hope Rising Health Services, LLC.

_____
Client Signature (or Guardian if under age 18)

_____
Date

_____
Clinician Signature

_____
Date