

*Bridges and Pathways Counseling Services*  
*Twin Cities*

Notice of Privacy Practices

Our Pledge

The privacy of your health information is important to us. We are required by law to protect the privacy of your health information. We must give you notice of our legal duties and privacy practices concerning “protected health information” or PHI including:

1. We must protect PHI that we have created or received about your past, present or future health condition, health care we provide to you or payment for your health care.
2. We must notify you about how we protect PHI about you.
3. We must explain how, when and why we use and/or disclose PHI about you.
4. We must notify you if there is a breach of unsecured PHI.
5. We may only use and/or disclose PHI as we have described in this notice.
6. We must abide by the terms of this notice.

We reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that we maintain. We will post a revised notice in our offices, and make copies available to you upon request.

Minnesota Patient Consent for Disclosures

For most disclosures of your health information we are required by the State of Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law. This consent may be obtained at the beginning of your treatment, during the first delivery of health care service or at a later point in your care, when the need arises to disclose your health information to others.

Uses and Disclosures

A. For purposes of treatment, Payment and Health Care Operations

1. Health Care Treatment: We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communication with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others.
2. Payment: we may use and disclose your medical information to others to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis. Before you receive scheduled services, we may share information about these services with your health plan. Sharing information allows us to ask for coverage under you plan or policy and for approval of payment before we

provide services. We may also share portions of your medical information with the following:

- a. Our billing service
  - b. Collection agencies
  - c. Insurance companies, health plans and their agents
  - d. Utilization review personnel that review the care you received to check that it and the costs associated with in were appropriate
  - e. Consumer reporting agencies
3. If you have paid for your services out-of-pocket, we will accommodate your request that the PHI related solely to those services paid for out of pocket not be disclosed to a health plan for payment or health care operations.

#### B. Requiring your Authorization

In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization, different from the Minnesota Patient Consent, to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

#### C. Require your Opportunity to Agree or Object

In the following instances we will provide you the opportunity to agree or object to a use or disclosure of your PHI:

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

**Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please contact your therapist.

#### D. Authorized by Law that Do Not Require Your Consent, Authorization or Opportunity to Agree or Object

Under certain circumstances we are authorized to use and disclose your health information without your consent or authorization from you or giving you the opportunity to agree or object. These include:

1. When the use and/or disclosure is authorized or required by law.

2. When the use and/or disclosure is necessary for public health activities.
3. When the disclosure relates to victims of abuse or neglect.
4. When the use and/or disclosure is for health oversight activities.
5. When the disclosure is for law enforcement purposes.
6. When the use and/or disclosure relates to decedents.
7. When the use and/or disclosure is to avert a serious threat to health or safety.
8. When the use and/or disclosure relates to specialized government functions.
9. When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations.

## Your Individual Rights

### A. To request restrictions on uses and disclosures of PHI

You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in this notice. You may request a restriction by submitting your request in writing to us. We will notify you if we are unable to agree to your request.

### B. To request communications via alternative means or to alternative locations, however, the confidentiality, security and privacy of information transmitted by email or text messages over the Internet cannot be assured because no one can guarantee the absolute security of the Internet. We prefer not to initiate a conversation with you by means of email or text messages and the best means of preserving the confidentiality, privacy and security of your information is to refrain from using email and text messages to communicate with us. Your transmission of email or text messages to us after you sign your consent form constitutes your (a) acknowledgment of such lack of guaranty of confidentiality, privacy and security, (b) consent that we may receive your messages and rely and act on them on your behalf and respond to such messages by the same means and (c) waiver, release and hold harmless of us regarding any claim you may have against us for our receipt of and reply to your messages and any interception or disclosure of your messages by an unauthorized third party.

### C. To see and copy PHI.

You have the right to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees instead of providing you with a full copy of the PHI; we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and the cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial.

### D. To request amendment of PHI.

E. To request an accounting of disclosures of PHI.

F. To receive a copy of this notice

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