

**Suzanne Kuchel, Ph.D.**  
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**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.**

Your health record contains personal information about you and your health. This information that identifies you and that relates to your past, present, or future physical or mental health or condition and health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the *APA Code Of Ethics*. It also describes your rights regarding how you may access and control your PHI.

I am required by law to maintain the privacy of PHI and to protect you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in my waiting area and by sending a copy to you by mail upon request.

**HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For treatment:** Your PHI may be used and disclosed by those involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to other consultants only with your authorization.

**For Payment:** I may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility of coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. Should it become necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for those purposes.

**For Health Care Operations:** I may use or disclose, as needed, your PHI in order to support our activities including, but not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing services) provided I have a written consent with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, your PHI will only be disclosed with your authorization.

**Required by Law:** Under the law, I must make disclosures of your PHI upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purposes of investigating and determining our compliance with the requirements of the Privacy Rule.

There are a number of categories of uses and disclosures permitted by HIPAA without an authorization from you. However, I hold myself to a higher standard and will only release the following categories of information without an authorization from you:

1. If I have reason to suspect abuse or neglect of a minor child or dependent adult.
2. If I have reason to suspect that another person is in imminent danger of being harmed.
3. If I have reason to suspect that your life or the life of another person is in imminent danger.
4. In emergency situations in which safety is deemed more important than privacy.
5. In matters of national security.

**Without Authorization:** Applicable legal and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

1. Required by law, such as the mandatory reporting of child or elder abuse or neglect, or mandatory government agency audits or investigations (such as by the Board of Mental Health Practice).
2. Required by a court order.
3. Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Verbal Permission:** I may disclose your information to family members that are directly involved in your treatment with our verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time.

## **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit a written request to me.

1. **Right of access to inspect and copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your rights to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based charge for copies.
2. **Right to Amend.** If you feel that the PHI I have about you is incomplete or inaccurate, you may ask me to amend the information, although I am not required to agree to the amendment.
3. **Right to an accounting of disclosures.** You may have the right to request an accounting of certain disclosures I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in a 12-month period.
4. **Right to request restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
5. **Right to request confidential communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
6. **Right to a copy of this notice.**

## **COMPLAINTS**

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me or with the New Hampshire Board of Mental Health Practice. **I will not retaliate against you for filing a complaint.**

**Notice of Privacy Practices Receipt and Acknowledgement of Notice**

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

**Date of Birth:** \_\_\_\_\_

**I hereby acknowledge that I have received and have been given an opportunity to read a copy of Suzanne Kuchel's Notice of Privacy Practices. I understand that if I have any questions regarding this information, I can contact Suzanne Kuchel at (603) 289-8838.**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent, Guardian, or Personal Representative**

\_\_\_\_\_  
**Date**

**If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)**

**Client refuses to acknowledge receipt:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of witness**

\_\_\_\_\_  
**Date**