Chloe Buckley, Ph.D, LLC
401 Kamake'e Street, Suite 405, Honolulu, HI 96814
Phone: (808) 277-3295

NOTICE OF PRIVACY PRACTICES

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your protected health information (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization:

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversations during counseling sessions, phone calls, emails or other communications, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that I have relied on a prior authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, since laws provide the insurer the right to contest claims under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization:

I may use or disclose PHI *without your consent or authorization* in the following circumstances:

• *Child Abuse* – If I have reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future, I must immediately report the matter to the appropriate authority.

• *Adult and Domestic Abuse* – If I, in the performance of their professional or official duties, know or have reason to believe that a dependent adult has been abused and is threatened with imminent abuse, I must promptly report the matter to the appropriate authority.

• *Health Oversight Activities* – If the Hawaii Board of Psychology is investigating my competency, license or practice, I may be required to disclose protected health information regarding you.

• *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the psychotherapy services provided to you and/or the records thereof, such information is privileged under Hawaii law, and I shall not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I shall inform you in advance if this is the case.

• *Serious Threat to Health or Safety* – I may disclose protected health information regarding you where there is clear and imminent danger to you or another individual or to society, and then only to appropriate professional workers or public authorities. If you are at risk, I may also contact family members or others who could assist in providing protection.

• *Worker's Compensation* – If you have filed a worker's compensation claim, I may be required to disclose PHI about any services I have provided to you that are relevant to the claimed injury.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights

• *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. I am not, however, required to agree to a restriction you request.

• *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in treatment. On your request, I will send your bills to another address.)

• *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

• *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

• *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

• *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from my office upon request, even if you have agreed to receive the notice electronically.

• *Right to Restrict Disclosures When You Have Paid For Your Care Out-of-Pocket* – You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.

Psychologist's Duties

• I am required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

• With limited exceptions, I am required to advise you of any breach of your PHI privacy of which I may become aware.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my policies and procedures, I will provide you with a revised notice.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Psychology Licensing Division of the State of Hawaii's Department of Commerce and Consumer Affairs. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice is effective as of March 1, 2015. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. I will provide you with a revised notice.

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have been provided with a copy of Dr. Chloe Buckley'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. My signature below attests that I have read and understood the above information in its entirety. I agree to accept and abide by these policies as a condition of receiving mental health services.

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Print Name	Signature	Date