



BRAVE CHOICES

A TWIN CITIES COUNSELING PRACTICE

Privacy Policy

March, 2020

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This notice describes how medical information about you may be used and disclosed under the federal health insurance portability and accountability act (HIPAA) and how you can get access to this information. The contents of this notice are in addition to and in accordance with the contents of the Service Agreement which is also required for you to review and sign prior to treatment.

Notice of Privacy Practices

Commitment to Your Privacy

Brave Choices, Inc., is dedicated to maintaining the privacy of your protected health information (PHI) as part of providing professional care. We are also required by law to keep your PHI private. This includes information collected about you and your mental and physical health issues and any identifying information such as your name, address, or date of birth. When it comes to your PHI, you have certain rights. This section explains your rights and some of our responsibilities to help you.

How Your Health Information May Be Used

We typically use or share your health information in the following ways.

- **To treat you:** We can use your health information and share it with other professionals who are treating you in order to provide the most effective treatment. Such exchanges of information require your written consent.
- **To run our practice:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, when entering your information into a billing system.
- **To bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities.
- **To contact you:** Unless specified by prior written notice, we can use your health information to contact you by telephone, voicemail, text message, or email to return a message or relay information to you.

Disclosing Your Health Information Without Your Consent

Brave Choices, Inc., will use or disclose your personal information for purposes of treatment, payment, and health care operations, in accordance with local, state, and federal law. Written consent is typically required before disclosing your personal information, however, in certain circumstances we may accept verbal permission when doing so is more expedient for meeting your needs. In certain cases, we are not required to obtain your authorization before disclosing personal information. Following are some examples of when we may disclose your personal information without your authorization:

- To first responder personnel if you experience an emergency on our premises.
- To the relevant state or county whenever a provider suspects abuse or neglect of a vulnerable adult has occurred within the last three years.
- In response to a court order. Your written consent is required before releasing your personal information in response to a subpoena.
- To a specific person or persons to whom you express a direct threat to in the presence of staff.
- To crisis services providers, hospital staff, law enforcement, or first responder personnel if you express intent to harm yourself or others.
- To law enforcement agencies to report suspicious wounds such as gun-shot wounds.
- To the military or other governmental agencies personnel under certain circumstances (such as to avert serious threat to public safety or to an individual, or to protect national security).
- To correctional institutions, if you are an inmate or in the custody of a law enforcement official, as necessary to provide you with healthcare, protect the health and safety of you or others, and to maintain the safety and security of the institution.

Your Rights Regarding Your Health Information

You have the right to:

- **Get an electronic or paper copy of your medical record:** You can ask to see or get an electronic or paper copy of your medical record and other health information. Ask your therapist how to do this. We will provide a copy or a summary of your health information within 30 days of your request. We will charge a fee of \$1.33 per page and a retrieval fee of \$17.68 per the 2016 rates set by the MN Department of Health.
- **Ask us to correct your medical record if you think is incorrect or incomplete.** These requests must be in writing and we may say “no” to your request, but we will tell you why in writing within 60 days.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.
- **Get a list of those with whom I've shared information:** You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. These requests must be in writing.
- **Ask me to limit what we use or share:** You can ask us not to use or share certain health information. We are not required to agree to your request, and we may say “no” if it would affect your care.
- **File a complaint if you feel your rights are violated.** If you feel your rights have been violated, you can complain by contacting your therapist, or by contacting Heather Holt, Brave Choices, Inc. President/Owner by using the information on the top of the first page of this document. You can also file a written complaint, without penalty, by contacting the U.S. Department of Health and Human Services Office for Civil Rights or the licensing board for your therapist. Contact information for the relevant Minnesota licensing boards appears at the bottom of this document.

- **Receive a copy of this notice at any time.** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website www.bravechoicesmn.com.

Responsibilities of Brave Choices, Inc.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must give you a copy of this notice and follow the duties and privacy practices described in this notice.
- We will not use or share your information other than as described here, unless you tell us that we can do so in writing. You may change your mind in regards to an Authorization for Release of Protected Health Information at any time by letting us know in writing.

Minnesota Board of Behavioral Health and Therapy
2829 University Ave SE, Suite 210
Minneapolis, MN 55414
(612) 548-2177

Minnesota Board of Social Work
2829 University Ave SE, Suite 340
Minneapolis, MN 55414
(612) 617-2100

Minnesota Board of Marriage and Family Therapy
2829 University Ave SE, Suite 400
Minneapolis, MN 55414
(612) 617-2220

Minnesota Board of Psychology
2829 University Ave. SE, Ste 320
Minneapolis, MN 55414
(612) 617-2230

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I, acknowledge that I have received Brave Choices's Notice of Privacy Practices, which describes how protected health information about me may be used and disclosed in providing services to me.

Client Name: _____

Client Signature: _____

Date: _____