Christina R. Perkins, LCSW
4877 Chambliss Ave
Knoxville, TN 37919
P: (865) 924-2558 F: 866-768-6708

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all healthcare providers to clearly explain the limits, potential uses, and your rights to access your Protected Health Information (PHI), meaning any identifying information, recorded during the course of treatment.

EXCEPTIONS TO CONFIDENTIALITY OF YOUR PROTECTED HEALTH INFORMATION (PHI)

Our therapeutic relationship is based on trust, and I fully appreciate and respect your right to privacy. I am required to retain a record of the care that I provide to you and will keep your information in a secure location in accordance with HIPAA standards both during and following treatment in accordance to state guidelines. Your PHI is considered confidential by law with the following exceptions:

SAFETY: If you are at imminent risk of suicide, killing another person, or knowingly exposing a nonconsenting identified person to a communicable and fatal disease, I will take measures to inform whichever parties necessary to ensure your safety and the safety of others who may be involved, including but not limited to hospitalization, a report to the appropriate authorities, and informing the identified target.

ABUSE: If I have knowledge of or suspect the abuse of a child, elder person, or adult who is under legal guardianship of another, I will make a report to the appropriate authorities.

LITIGATION: If I receive a court order from a judge for your PHI regarding a legal matter in which you are involved, I may be required to share your PHI.

HEALTH OVERSIGHT ACTIVITIES: If an agency responsible for monitoring the health care system for activities authorized by law, including but not limited to audits, investigations, inspections and licensure, your PHI may be included in the review to ensure the quality of care that I am providing.

FINANCIAL REIMBURSEMENT FOR SERVICES RENDERED: If your therapy services are being paid in part or full by a health insurance company, Employee Assistance Program, or worker's compensation claim, I will be required to share your PHI to be reimbursed for provided services to the involved agency/agencies and to my billing agent, Wendy Rhodes, CPC, CPC-H, CPMA. Also, if you are in default on payment of a therapy bill, I have the right to involve a collection agency or small claims court, in which case your PHI will be shared.

CONTINUATION OF TREATMENT: If your therapy services are being paid in part or full by a health insurance company, Employee Assistance Program, or worker's compensation claim, I may be required to share your PHI to ensure continuation of treatment.

CLIENTS UNDER GUARDIANSHIP: If you are a minor or an adult under legal guardianship of another, your PHI may be shared with your legal guardian(s) unless I believe that doing so would compromise your physical or mental health in any way. I will always first encourage direct communication between you and your legal guardian(s) when possible and appropriate to avoid the need for my disclosure of your PHI.

AUTHORIZED RELEASE OF INFORMATION: If you sign a release permitting me to share your PHI with another person or agency, I will do so within the limits of the release. You may revoke any release at any time in writing.

If I should ever be required to disclose your PHI, I will make a reasonable effort to contact you and discuss the matter explicitly before your PHI is released and limit shared information to only what is absolutely necessary to fulfill the purpose of the disclosure.

Christina R. Perkins, LCSW
4877 Chambliss Ave
Knoxville, TN 37919
P: (865) 924-2558 F: 866-768-6708

YOUR RIGHTS REGARDING YOUR PHI

By law, I must have your written permission to use or give out your PHI for any purpose not outlined in this policy. If you provide me with permission to use or disclose your PHI, you may revoke that permission in writing at any time, and I will no longer use or disclose your PHI for the reasons covered by your written authorization; however, I will be unable to retract any disclosures I have already made with your permission.

As a consumer of healthcare services, you have the following rights related to your PHI:

RIGHT TO REQUEST RESTRICTIONS OF PHI: You may request limitations on how I use your PHI. If it is regarding one of the above outlined exceptions to confidentiality, I will consider your request, but do not have to agree to it. If we do agree to the restrictions, we will put the agreement in writing and follow it within the bounds of my required disclosure.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OF PHI: You have the right to ask that I communicate with you regarding your PHI by specific means and at specific locations, including but not limited to calling to schedule appointments, mailing bills, and whom I may communicate with regarding your PHI (for example, whether I may leave a message with a family member). I will accommodate all reasonable requests.

RIGHT TO INSPECT AND RECEIVE COPIES OF YOUR PHI: You may make a written request to inspect and/or copy your PHI. You may also request a summary of the PHI in lieu of the complete record. In some situations, I may deny your request to view and copy your PHI in its entirety and provide you with a summary letter, as is my right.

RIGHT TO RECEIVE THIS NOTICE: You have the right to receive a paper copy of this notice upon request. If changes are made to this privacy notice while you are an active client or by the time I am required to disclose your PHI after therapy services have ended, you will be notified and can request a copy of the revised notice. The most current notice will be posted in my office at the above listed address.

ELECTRONIC COMMUNICATION: **You have the choice of whether to authorize me to leave voice messages _____ and whether I can send text messages _____ on the following phone number(s):_____. By signing below you understand that I am not responsible for involuntary disclosure of your information due to an unsecured phone.**

*BY SIGNING BELOW, I attest that I have read and received a copy of this document and have had any questions about this document answered by my therapist:

Client/Guardian Name:_____

Client/Guardian Signature: _____ Date:_____

Therapist Signature: _____ Date: _____

Christina R. Perkins, LCSW
4877 Chambliss Ave
Knoxville, TN 37919
P: (865) 924-2558 F: 866-768-6708