

**ABBY LEACH, LMHC**  
Counseling & Consultation Services PS Inc  
1204 E. 4<sup>th</sup> Avenue Ste #1~Olympia, WA 98506  
(360) 786-8659 License #5935

**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.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether on paper, orally or electronically to be kept confidential. This federal law gives you, the patient, new rights to understand and control how your personal health information and how we may use and disclose this information.

**Verbal Permission**

I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**Compulsory Process**

I will disclose your HIPPA if a court of competent jurisdiction issues an appropriate order. I will disclose your HIPPA if you and I have each been notified in writing at least 24 days in advance of a subpoena or other legal demand, and no protective order has been obtained, and I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.

**With Authorization**

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

**YOUR RIGHTS REGARDING YOUR HIPPA**

You have the following rights regarding HIPPA; I maintain about you:

**Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy HIPPA that may be used to make decisions about your care. Your right to inspect and copy HIPPA 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 fee for copies.

**Right to Amend.** If you feel that the HIPPA I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that I make of your HIPPA.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your HIPPA for treatment, payment, or health care operations. I am not required to agree to your request.

**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.

**Right to Copy of this Notice.** You have the right to a copy of this notice.

**Right of Complaint.** You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you filing a complaint.

### **CONTACT INFORMATION**

I am my own Privacy Officer. If you have any questions about this Notice of Privacy Practices, please contact me. My contact information is:

Abby Leach LMHC  
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(360) 786-8659  
Washington License # 5935  
NBCC # 40249

### **COMPLAINTS**

If you believe I have violated your privacy rights, you have the right to file a complaint in writing to me as my own Privacy Officer (see CONTACT INFORMATION above) or with the:

Secretary of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington D.C. 20201  
or by calling (202) 619-0257.

**I will not retaliate against you for filing a complaint.**

The effective date of this Notice is April 14, 2003