



**Bill McClain, LCSW**

*Individual & Family Counseling*

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## **Notice of Privacy Practices**

**This notice describes how clinical information about you may be used and disclosed and how you can get access to this information.**

**PLEASE REVIEW THIS CAREFULLY**

**If you have any questions about this notice,  
please contact Bill McClain, LCSW**

The law requires that I give you this notice. More information is available if you ask. I am bound by and follow all state and federal laws regarding provision of psychotherapy/counseling, as well as the National Association of Social Workers' Code of Ethics. When there is a disagreement between state and federal laws, I must follow the most stringent.

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

I may *use* or *disclose* your *protected health information*, for *treatment, payment, or health care operations* purposes with your *consent*. Here are some definitions to help define these terms.

**Protected Health Information** refers to information in your health record that could identify you.

**Treatment** means when I speak with other people involved in your or your child's care such as the physician, teacher or another psychotherapist.

**Payment** means billing and collecting payment from you, your insurer or another third party.

**Health Care Operations** are activities relating to the performance and operation of my practice. Examples would include quality assessment and improvement activities, calling you to reschedule an appointment, business-related matters such as audits.

**Use** applies to activities within my office, such as sharing, employing, applying, or utilizing information that identifies you.

**Disclosure** applies to activities outside my office, such as releasing or providing information about you to other parties.

### **II. Uses and Disclosures Requiring Authorization**

I may use or disclose *protected health information* for purposes of treatment, payment and health care operations when your authorization is obtained. An “**authorization**” is written permission above and beyond the general consent that permits only specific disclosures under specific legally mandated circumstances. In those instances when I am asked for information for information for purposes of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information.

I will also need to obtain a separate authorization before releasing your psychotherapy notes. “**Psychotherapy notes**” are notes I have made about our discussions during individual, group, joint, or family counseling sessions, which I keep separate from the rest of your medical record. By law, these notes are given a greater degree of protection than *protected health information*.

You may revoke all such authorizations of *protected health information* or *psychotherapy notes* at any time. I may use your authorization as long as it is in effect and will stop using it at the point you choose to revoke it in writing. You may not revoke the authorization if it was obtained as a condition of obtaining insurance reimbursement or coverage, and the law provides the insurer the right to contest the claim under the policy.

### **III. Uses and Disclosures With Neither Consent nor Authorization**

I am required by my professional Code of Ethics and by Oregon State Law to act to maintain your safety and the safety of others. I may use or disclose *protected health information* without your consent or authorization in the following circumstances:

**Child abuse:** If there is a child abuse investigation, I may be compelled to turn over your relevant records.

**Elder and domestic abuse:** If there is an elder abuse or domestic violence investigation, I may be compelled to turn over your relevant records.

**Health Oversight:** The Oregon State Board of Clinical Social Workers may subpoena relevant records from me should I be the subject of a complaint.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and other treatment records thereof, such information is privileged under state law, and I must not release your information without written authorization by or your personal or legally-appointed representative, or court order. This privilege does not apply when you are being evaluated for a third party or when the evaluation is court-ordered. You will be informed in advance if this is the case.

**Serious Threat to Health or Safety:** I may disclose confidential information when I judge that disclosure is necessary to protect against clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. I must limit disclosure of otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.

**Worker’s Compensation:** If you file a worker’s compensation claim, this constitutes authorization for me to release your relevant mental health records to involved parties and officials. This would include a past history of complaints or treatment of a condition similar to that complaint.

#### **IV. Clients' Rights and Psychotherapist's Duties**

##### **Clients' Rights:**

**Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of *protected health information* about you. Your request must be made in writing. However, I am not required to agree with a restriction made in the request.

**Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of *protected health information* by alternative means and at alternative locations. For example, you may not want a family member to know you are in psychotherapy. Upon your request I will send your bills to another address.

**Right to Inspect and Copy:** You have the right to inspect and/or obtain a copy of *protected health information* in my mental health and billing records used to make decisions about you for as long as the *protected health information* is maintained in the record. I may deny your access to *protected health information* under certain circumstances, but in some cases, you may have this decision reviewed. At your request, I will discuss with you the details of the request and denial process.

**Right to Amend:** You have the right to request an amendment of *protected health information* for as long as the *protected health information* is maintained in the record. Your request may be denied under certain circumstances.

**Right to Accounting:** You generally have the right to receive an accounting of disclosures of *protected health information* for which you have neither provided consent nor authorization, (as described in Section III of this Notice). 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 this notice from me upon request.

##### **Psychotherapist's Duties:**

I am required by law to maintain the privacy of *protected health information* and to provide you with notice of my legal duties and privacy practices with respect to *protected health information*.

I reserve the right to change the privacy practices described in this Notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect. If I revise my policies and procedures I will advise in writing during a session or by mail.

##### **Complaints:**

I am committed to preserving and protecting the privacy of your health information. If you are concerned about your privacy rights, or if you have any questions, concerns, or complaints regarding the decisions made about access to your records, please let me know

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You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services or the Oregon State Board of Clinical Social Workers. I can provide you with the appropriate address upon request. You will not be penalized for filing a complaint.

Other disclosures may be required by HIPPA law. It is my policy not to disclose any other information without your authorization. However, once information leaves my practice, I cannot control its flow.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that are maintained. Any revised notice will be in writing and shared with you during our session or by mail.