

**Marti Hickey, LICSW**  
753 N. 35<sup>th</sup> Street, Suite 101  
Seattle, Washington 98103  
marti.hickeylicsw@gmail.com  
206.565.1332

### **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.**

I am required by law to maintain the privacy of your health information. I am also required to give you this notice about my privacy practices, legal obligations, and your rights concerning your health information (referred to here as “personal information”). Examples of your personal information include your name, Social Security number, address telephone number, medical/psychosocial history, therapy records, claims information, etc. This Notice of Privacy Practices informs you about how I may collect, use and disclose your personal information, and about your rights regarding that information.

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#### **My responsibility to protect your personal information**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I must take measures to protect the privacy of your personal information. For example, I authorize access to your personal information only to the extent necessary to conduct the business of serving you. In addition, I take steps to secure client files and information from unauthorized access. I will protect the privacy of your information even if you are no longer in treatment with me.

#### **How I may collect, use and disclose your personal information**

I may collect your personal information from these sources: in the course of accepting referral information to assess your eligibility for services, from you directly and/or from individuals you specifically authorize to share information with me to ensure good coordination of your care.

I may use or disclose your personal information without your specific authorization for the following purposes:

**Payment:** I may use and disclose personal information to assist you in processing your insurance claims. However, state laws may prohibit me from disclosing certain types of sensitive personal information about you to insurers or to others without your specific authorization.

**Consultation:** One way I ensure that you receive the highest quality of care possible is through the use of professional consultation. I have agreements with professional consultants and require them to maintain the confidentiality of your personal information. I have a commitment to share as little personal information as possible when seeking consultation.

**As required by law:** I may use or disclose your personal information when required by federal, state or local law. For example, I may be required to disclose personal information to a health oversight agency for activities such as audits, investigations or related to licensure. Personal information may be required to be disclosed in response to a court order or subpoena, or to law enforcement officials during certain investigations.

**Public Health and Safety:** I may disclose personal information about you to the extent necessary to avert a serious and imminent threat to your health or safety, or to the health or safety of others.

**For all other purposes:** I will request your specific authorization in writing, which you may grant or reject. If granted, authorizations typically remain in effect for one year (unless otherwise stated) and automatically expire thereafter. You are free to revoke your authorization at any time by letting me know in writing.

## **YOUR RIGHTS REGARDING PERSONAL INFORMATION**

You have the following rights regarding personal information that I maintain about you:

**Inspection—**You have the right to request inspection and to receive a copy of a record of your personal information. For a copy of your record, I will charge you a reasonable fee to cover copying and supply costs. Your request must be made in writing.

**Amendment—**If you feel the personal information that I maintain about you is incorrect or incomplete, you have the right to request amendment to it. The final decision, however, shall be mine.

**Restriction Request—**You have the right to request a restriction or limitation on the personal information I disclose about you for treatment, payment or coordination of your care.

**Confidential Communications—**You have the right to request that I communicate with you about your treatment at a location that assures utmost privacy. For example, you may ask that I only contact you at your work address/phone.

**Accounting Disclosures—**You have the right to an accounting of disclosures I have made. The first list you request within a 12 month period will be free. For additional lists, I may charge you a reasonable fee to cover copying and supply costs. All of these requests must be made in writing.

## **COMMUNICATION**

Many people find email a convenient way to communicate regarding appointment scheduling. Please note that email is not secure and I cannot guarantee information transmitted will remain confidential. When you choose to communicate client identifiable information via email, you are consenting to the associated risks.

## **REPORTING A PROBLEM**

If you believe your privacy rights have been violated or if you disagree with a decision I have made about a request, you may file a written complaint with me or with the Washington State Department of Health, Health Systems Quality Assurance, Complaint Intake, PO Box 47857, Olympia, WA 98504-78.