



Desire Blooms, PLLC  
Counseling & Sex Therapy

Karina StarkHart, MA, LMHCA

## HIPAA COMPLIANCE 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. This information will include Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as applicable, [RCW Chapter 70.02](#) entitled "Medical Records - Health Care Access and Disclosure."

Please review this document carefully before signing.

I respect your privacy. I understand that your personal health information is very sensitive. I am committed to protecting your health information and I will not disclose your information to others except at your direction, or unless the law authorizes or requires me to do so. The law protects the privacy of the health information I create and obtain in providing care and services to you. It is always my goal and responsibility to ensure your privacy and wellbeing are maintained.

### Protected Health Information:

- *Protected health information* means individually identifiable health information:  
Transmitted by electronic media;
- Maintained in any medium described in the definition of electronic media; or
- Transmitted or maintained in any other form or medium.

### I am required by law to:

- Make sure that PHI that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.

I can change the terms of this notice, and such changes will apply to all the information I have about you. The new Notice will be available upon request and on my website.



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## Certain Uses and Disclosures Require Your Authorization:

1. **Psychotherapy Notes.**

I keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501. Any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

- a. For my use in treating you.
- b. For my use in training or supervising mental health practitioners to help them improve their skills in counseling or therapy.
- c. For my use in defending myself in legal proceedings instituted by you.
- d. For use by the Secretary of the Department of Health and Human Services (HHS) to investigate my compliance with HIPAA.
- e. Required by law and the use or disclosure is limited to the requirements of such law.
- f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
- g. Required by a coroner who is performing duties authorized by law.
- h. Required to help avert a serious threat to the health and safety of others.

2. **Marketing Purposes.** I will not use or disclose your PHI for marketing purposes (such as publishing your testimonial or review) without your prior written consent. You may withdraw this consent at any time by submitting a written request to me via the email address I keep on file or via certified mail to my address. Once I have received your written withdrawal of consent, I will remove your review from my website and from any other places where I have posted it. I cannot guarantee that others who may have copied your review from my website or from other locations will also remove the review. This is a risk that I want you to be aware of, should you give me permission to post your review.

3. **Sale of PHI.** I will not sell your PHI.

## Uses and Disclosures That Do Not Require Your Authorization:

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons. I have to meet certain legal conditions before I can share your information for these purposes:



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1. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.
2. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
3. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
4. For health oversight activities, including audits and investigations.
5. For judicial and administrative proceedings, including responding to a court or administrative order or subpoena, although my preference is to obtain an Authorization from you before doing so if I am so allowed by the court or administrative officials.
6. For law enforcement purposes, including reporting crimes occurring on my premises.
7. To coroners or medical examiners, when such individuals are performing duties authorized by law.
8. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. For organ and tissue donation requests.

## Certain Uses and Disclosures Require You to Have The Opportunity to Object:

**Disclosures to family, friends, or others:** You have the right and choice to tell me that I may provide your PHI to a family member, friend, or other person whom you indicate is involved in your care or the payment for your health care, or to share you information in a disaster relief situation.

The opportunity to consent may be obtained retroactively in emergency situations to mitigate a serious and immediate threat to health or safety or if you are unconscious.



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## HIPAA: CLIENT RIGHTS

1. You have the right to request where I contact you: home, work, cell, email, or some other means of your choice.
2. You have the right, by written authorization, to release your medical records to others. You also have the right to revoke that release in writing. Revocation is not valid to the extent that I have already acted in reliance on your previous authorization.
3. You have the right to make a written request to view and obtain an electronic or paper copy of your records. A copy of your records, or if you agree, a summary of it will be provided within 30 days of receipt of your request. You will be charged \$0.15 per page for printed copies of records in addition to any mailing costs. I may, under some circumstances, deny this request.
4. You have the right to make a written request that I amend your records. I will have at least 30 days to decide whether to amend your records as you have requested and, in some instances, may deny your request. If your request is denied, I will tell you why in writing within 60 days of receiving your request. You have the right to file a disagreement statement in such instances. Your disagreement statement and my response will be filed in the record.
5. You have the right to make a written request for an accounting of disclosures made of your health information with the following exceptions: disclosure for treatment, payment, or healthcare operations; disclosures pursuant to a signed release; disclosures made to the client; disclosures for national security or law enforcement purposes. I will respond to your request for an accounting of disclosures made in the last six years (unless a shorter time is requested) within 60 days of receiving your request. You will be charged \$0.15 per page for printed copies in addition to any mailing costs.
6. You have the right to make a written request to restrict uses and disclosures of your healthcare information; however, I am not obligated to agree to your request, and I may say "no" if I believed it would affect your health care.
7. You have the right to receive both electronic and paper copies of this notice. You may request a paper copy at any time, and one will be mailed to you.
8. You have the right to choose someone to act for you. If you have given someone medical power of attorney, or if someone is your legal guardian, that person can make choices about your health information.
9. You have the right to revoke an authorization.
10. You have the right to complain if you feel I have violated your rights by contacting me or by filing a complaint with the [U.S. Department of Health and Human Services](https://www.hhs.gov/office-for-civil-rights/) via the provided link, at their Office for Civil Rights located at 200 Independence Avenue, SW, Washington DC 20201, or by phone at (877) 696-6775. I will not retaliate against you for such complaints.
11. You have the right to receive changes in policies.