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COLORADO HIPAA NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

BY SIGNING THE CLIENT INTAKE FORM, YOU ACKNOWLEDGE THAT YOU HAVE HAD THE OPPORTUNITY TO READ THIS DOCUMENT AND/OR YOUR PROVIDER HAS VERBALLY EXPLAINED IT TO YOU. YOU MAY ALSO PRINT A COPY OR ASK YOUR PROVIDER FOR A COPY.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

Your provider may *use or disclose your protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
 - *Treatment* is when your provider provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your provider consults with another health care provider, such as your family physician or another therapist.
 - *Payment* is when C4VL obtains reimbursement for your healthcare. Examples of payment are when your provider discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of your provider's practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within your provider's [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of your provider's [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- Records are maintained on computer; fax and electronic transmission is utilized on an ongoing process, not a one-time occurrence.

II. Uses and Disclosures Requiring Authorization

Your provider may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your provider is asked for information for purposes outside of treatment, payment or health care operations, they will obtain an authorization from you before releasing this information. They will also need to obtain an authorization before releasing your Psychotherapy Notes, which may only be done under certain circumstances. *"Psychotherapy Notes"* are notes your provider has made about their conversation during a private, group, joint, or family counseling session, which they have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Your provider may use or disclose PHI without your consent or authorization in the following circumstances:

- ***Child Abuse*** – If they have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, they must immediately report this to the appropriate authorities.
- ***Adult and Domestic Abuse*** – If they have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then they must report this belief to the appropriate authorities.
- ***Health Oversight Activities*** – If the Colorado State Board or DORA or an authorized professional review committee is reviewing their services, they may disclose PHI to that board or committee.
- ***Judicial and Administrative Proceedings*** – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and they will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- ***Serious Threat to Health or Safety*** – If you communicate to your therapist a serious threat of imminent physical violence against a specific person or persons, they have a duty to notify any person or persons specifically threatened, as well as a duty to notify an appropriate law enforcement agency or by taking other appropriate action. If they believe that you are at imminent risk of inflicting serious harm on yourself, they may disclose information necessary to protect you. In either case, they may disclose information in order to initiate hospitalization.
- ***Worker's Compensation*** – They may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provided benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Providers' Duties

Patient's Rights:

- ***Right to Terminate Services or Therapy***- If you wish, your provider can provide you with the names and phone numbers of other qualified mental health professionals or you can cease treatment all together.
- ***Right to Information***- You are entitled to ask questions about the procedures used during therapy

or psychological testing, the approximate duration of your treatment (if it can be determined) and the C4VL fee structure and policies they use.

- **Prevent Electronic Recording**- You can decide whether any part of your treatment is recorded and permission to record must be granted by you in writing explaining the purpose for the recording and for what time period the recording will take place. You have the right to withdraw your permission to record at any time.
- **Avoid Dual Relationships with Your Provider**- The relationship with your provider(s) should remain strictly professional. In this regard, it is unethical and illegal for your provider(s) to engage in any sexual behavior with any client, at any time. If any sexual behavior occurs, a written complaint should be sent to DORA or a phone call can be made to that agency. The address, phone # and website for that agency are listed below.
- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, your provider is not required to agree to a restriction of you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing your provider. On your request, C4VL will send your bills to another address.)
- **Right to Inspect and Copy**– You have the right to inspect or obtain a copy (or both) of PHI in your provider’s mental health and C4VL billing records used to make decisions about you for as long as the PHI is maintained in the record. Your provider may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, your provider will discuss with you the details of the request and denial process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your therapist may deny your request. On your request, they will discuss with you the details of the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI. On your request, your provider 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 the notice from your provider upon request, even if you have agreed to receive the notice electronically.

Provider's Duties:

- Your provider is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI.
- C4VL reserves the right to change the privacy policies and practices described in this notice. Unless C4VL notifies you of such changes, however, C4VL and its provider are required to abide by the terms currently in effect.
- If C4VL revises its policies and procedures, the revised version will be available on the website c4vl.com.

V. Professional Records

Your provider keeps Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It may include information about your reasons for seeking treatment, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that they set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that your provider receives from other providers, reports of any professional

consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. These records are kept for seven years from the last DOS (or seven years from the time a child client turns 18) and after seven years, may be destroyed or shredded. Except in unusual circumstances, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Your provider legally has the right to refuse review if they deem it would be clinically detrimental to you. In most situations, your provider is allowed to charge a per-page copying fee. If they refuse your request for access to your Clinical Record, you have a right of review, which they will discuss with you upon request.

In addition, your provider may also keep a set of Confidential Therapy Notes. These notes are for their own use and are designed to assist them in providing you with the best treatment. While the contents of Confidential Therapy Notes vary from client to client, they can include the contents of the session as it pertains to you, their analysis of that information, and how it impacts your treatment. They also contain particularly sensitive information that you may reveal that is not required to be included in your Clinical Record and information that has been supplied to your provider confidentially by others. These Confidential Therapy Notes are kept separate from your Clinical Record. Your Therapy Notes are not available to you and cannot be sent to anyone else, including insurance companies. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it. Your Clinical Record and/or Confidential Therapy Notes may be contained in both an electronic and paper record, and both are secured per HIPAA requirements.

VI. Complaints

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision they made about access to your records, you may contact:

Colorado Civil Rights Division

1560 Broadway, Suite 825

Denver, Colorado 80202

(303) 894-2997

<https://ccrd.colorado.gov/>

_____ Client (18+) or Parent / Guardian Full Name	_____ Client (18+) or Parent / Guardian Signature	_____ Date
Required if shared decision-making		
_____ Additional Parent / Guardian Full Name	_____ Additional Parent / Guardian Signature	_____ Date