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**Signature required below*

This notice describes how psychological and medical information about you may be used and disclosed and how you can obtain access to this information. Please review and retain this copy for your records.

I am required by law to maintain the privacy of your protected health information, (PHI), and to provide you with this notice, which explains my legal duties and privacy practices with respect to your PHI. I must abide by the terms set forth in this notice. However, I reserve the right to change the terms of this notice and make new notice provisions effective for all PHI.

I. Uses and Disclosures for Treatment, Payment and Healthcare Operations.

I may use or disclose your PHI for treatment, payment and healthcare operation purposes with your consent. To help clarify these terms, here are some definitions:

PHI (Protected Health Information): Information in your health record that could identify you.

Treatment, Payment and Healthcare Operations: **Treatment** is when I provide, coordinate or manage your health care and other services related to your healthcare, such as a psychiatric consultation. **Payment** is when I obtain reimbursement for your healthcare, such as submitting a claim with your PHI to get paid. **Healthcare Operations** are activities that relate to the performance and operations of my practice, such as quality assessment, administrative improvements, and patient care management. I may also disclose your PHI to third-party business associates who assist in healthcare operations, such as a billing service.

Use: Activities within my office, such as sharing, applying, utilizing and analyzing information, that may identify you.

Disclosure: Activities outside my office, such as providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization.

I may use or disclose PHI for purposes outside 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 I am asked for information for purposes outside of the general consent or in any way that is not described in this notice, I will obtain an authorization from you before releasing this information. You may revoke all authorizations to release information at any time, provided each revocation is in writing. You have the right to restrict certain disclosures of PHI to a health plan if you have paid out-of-pocket in full for a therapeutic service. You may not revoke an authorization to the extent that: (1) I have relied on that authorization; or, (2) the authorization was obtained as a condition of insurance coverage.

III. Uses and Disclosures with Neither Consent nor Authorization.

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

Serious Threat to Health or Safety: If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose this information to initiate hospitalization procedures in an effort to protect you. If you express an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe that you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and to the police.

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Child Abuse: If I have reason to believe that a minor is or has been the victim of neglect, physical and/or sexual abuse, I am required to report this to Arizona Department of Child Safety (DCS). This includes any information you may have that a minor is being abused, including child pornography.

Adult and Domestic Abuse: If I have reason to believe that an incapacitated or vulnerable adult has been subjected to abuse or neglect, or that exploitation of their property has occurred, I am required to report this to Arizona Adult Protective Services (APS).

Health Oversight Activities: If the Arizona Board of Psychologist Examiners is conducting an investigation, I am required to disclose PHI upon receipt of a subpoena from the Board.

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

Worker's Compensation: I may disclose PHI as authorized by and to comply with laws related to worker's compensation or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Other: When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions, such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties.

Patient's Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of certain PHI, e.g., to persons involved in your care. Although not required to agree, if I do agree then I will comply with your request unless the information is needed for emergencies.

Patient's Right to Receive Confidential Communication 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, e.g., you may not want a family member to know that you are seeing me, so I can contact you at a different telephone number or mail items to a different address. Requests must be in writing.

Patient's Right to Inspect and Copy: You have the right to inspect, take notes, photograph, and/or obtain a copy of PHI in my mental health and billing records as long as the PHI is maintained in the medical record. In Arizona, the statute for keeping closed medical records is seven years. Records are stored electronically. If you wish to inspect or obtain a copy of your medical information, you must submit your request in writing. I generally recommend reviewing your mental health record with you prior to release and I may charge a fee to fulfill your request. I have fifteen days to respond to your request for information.

Patient's Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained

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in the record. You must make this request in writing and state the reason for amendment. I may deny your request for the information if: (1) it was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; (2) it is not part of the record which you are permitted to inspect and copy; (3) it is not part of our designated record; or, (4) it is already accurate and complete, in my opinion.

Patient's Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI, except for: (1) disclosures made to you; (2) disclosures for treatment, payment, or health care operations; (3) incidents to use or disclose set forth in this notice; (4) disclosures made to law enforcement officials. Your request must be in writing and must state the time period for the requested information. We may charge you a fee for your request, will notify you of such costs, and respect your decision to withdraw because of cost.

Patient's Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Patient's Right to Be Notified if There is a Breach of Your Unsecured PHI: You have the right to be notified if: (a) there is a breach (use or disclosure of your PHI in violation of HIPAA Privacy Rule involving your PHI); (b) that PHI has not been encrypted to government standards; and, (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Patient's Right to a Paper Copy: You have the right to obtain a paper copy of this notice.

Psychologist's Duties: I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described herein and will notify you of such changes.

Complaints: If you are concerned that I have violated your privacy rights, or you disagree with a decision made about access to your record, please contact me with your complaint in writing. You may also send a complaint to: Office of the Secretary, USDHHS, 200 Independence Avenue, SW, Washington, DC, 20201.

Effective Date, Restrictions and Changes to Privacy Policy: I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a review notice of changes that might affect you by mail. This notice is effective as of January 1, 2023.

Notice of Privacy Practice Consent

Please sign and date the following consent:

I have received a copy of the HIPAA Notice of Privacy Practices and have reviewed any questions or concerns I might have with Dr. Newell.

Signature

____/____/_____
Date