UNIVERSITY of VIRGINIA
SCHOOL of EDUCATION and HUMAN DEVELOPMENT
Sheila C. Johnson Center

Sheila C. Johnson Center
417 Emmet Street
P.O. Box 400270
Charlottesville, VA 22904-4270
Phone: 434-924-7034 ● Fax: 434-924-4621
education.virginia.edu/research-initiatives/sheila-c-johnson-center

1. Download form to your computer desktop.
2. Open form with Adobe Reader, available at https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html
3. Save form after filling in the fields.
4. Return form via OnPatient

# Provider 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.***

This notice described the privacy practices of the University of Virginia Sheila C. Johnson Center, including discipline-specific services. The following categories describe different ways that we may use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. With your consent, we may use and disclose your protected health information to provide, coordinate or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment. We may use and disclose medical information about you so that the treatment and services received may be billed to and payment may be collected from you, an insurance company or another third party. We may also tell your health plan about a treatment you are going to receive, to obtain prior approval or to determine whether your plan will cover treatment. If you want your health plan not to receive information about treatment for which you have paid in advance, see "Right to Request Restrictions" in this notice.

Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may provide information in the aggregate to teachers and students in our graduate training programs for review and learning purposes.

Individuals Involved in Your Care or Payment for Your Care. With your consent, we may release information about you, such as appointment times or billing information, to a family member or friend who is involved in your care, or the payment for your care.

Other Care Providers. With your consent, we may disclose medical information to other health care professionals who have cared or currently are caring for you, for them to use in treating you, seeking payment for treatment, and certain health care operations, such as evaluating the quality of their care and the performance of their staff, providing training, and licensing and accreditation reviews.

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. Similarly, there are departments of the University that provide services to us, and may need access to your health information to do their jobs. Examples of these services include information technology specialists servicing our HIPAA-complaint electronic medical records. We require business associates and other UVA departments to appropriately safeguard your information.

As Required By Law. We may disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent an immediate, serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans. We may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. With your consent, we may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose medical information about you for public health activities, such as to report abuse or neglect of children, the elderly and incompetent patients, or reactions to medications or problems with products.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose medical information about you in response to a court order, search warrant, or a subpoena but only if efforts have been made to tell you about the subpoena.

Research. We may use and disclose medical information about you for research. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. In most cases, your authorization would be required. In other cases where the review process determines that the project creates minimal risk to privacy, it would not. We may disclose medical information about you to people preparing to conduct a research project, for example, to help them look or patients with specific medical needs, so long as the medical information they review does not leave the Center. And if a research project can be done using medical data from which all the information that identifies you has been removed, we may use or release the data without special approval. We may use or release data for research with a few identifiers retained---such as age, gender, and treatment. However, in this case we will have those who receive the data sign an agreement to appropriately protect it.

Social Security Numbers. We may collect your social security number. We use social security numbers for identification and verifications (for example, to provide the right medical record when two patients have the same name). We also are required to collect social security numbers by Virginia law (VA. Code 58.1-521) for use if needed in the administrative offset program. Some other government programs, such as Medicaid, require social security numbers. Providing a social security number is voluntary, except for applicants to governmental programs that require it. The privacy practices in this Notice apply to your social security number.

## *YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU*

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. In most cases, you have the right to inspect and copy your medical and billing records. To inspect and copy your medical or billing records, you must submit your request in writing to Sheila C. Johnson Center for Clinical Services, P.O. Box 400270, Charlottesville, VA 22904. If you request a copy of the information, we may charge a fee for costs for copying and mailing. You may request copies of records in an electronic format, and if the records are available in that format, they will be provided in it. If they are not, we will provide an alternate format.

We may deny your request to inspect and copy in some circumstances. We may deny your request to inspect and copy in certain very limited circumstances. If we do, you may request that the denial be reviewed. Another licensed health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

For Psychotherapy Services. Psychotherapy Notes are specifically defined in the HIPAA regulations as "notes recorded in any medium by a mental health provider documenting or analyzing the contents of a conversation during a private, group, joint or family counseling session, and that they are separated from the rest of the individual's medical record" and are treated differently than other medical records. Psychotherapy Notes must be kept in a separate file and are considered the private self-communication of the mental health provider. HIPAA does not allow patients specific access to Psychotherapy Notes. In contrast, mental health records are available to clients and include the following types of information: counseling session dates, diagnoses, functional status, treatment plan, symptoms, prognosis, progress to date, termination summary, and psychological testing reports. These are usually more accessible to you.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment your request must be made in writing and submitted to the Sheila C. Johnson Center for Clinical Services, P.O. Box 400270, Charlottesville, VA 22904. In addition, you must provide a reason that supports your request. We may deny your request if you ask us to amend information that:

- Was not created by us; we will add your request to the information record;
- Is not part of the medical information kept by the Center;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of medical information about you that were not for treatment, payment or health care operations and of which you were not previously aware. To request this list of accounting of disclosures, you must submit your request in writing to the Sheila C. Johnson Center for Clinical Services, P.O. Box 400270, Charlottesville, VA

22904. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions. You have the right to restrict disclosure of health information to your health plan for services paid out of pocket in full prior to the service being provided. This right applies only if the disclosure is to a health plan for purposes of payment or health care operations and the health information relates to a health care item or service for which you have paid in full prior to the service. You have the right to request other restrictions on the information we use or disclose about you for treatment, payment of health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request for these other restrictions. To request restrictions, you must make your request in writing to the Sheila C. Johnson Center for Clinical Services, P.O. Box 400270, Charlottesville, VA 22904. In your request, you, must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Receive Notice of Any Breach. You have the right to receive written notice from us if there has been a breach of your identifiable health information.

Right to Request Alternative Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request alternative communications, you must make your request in writing to the Sheila C. Johnson Center for Clinical Services, P.O. Box 400270, Charlottesville, VA 22904. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

## CHANGES TO THIS NOTICE

We have the right to change this notice and make the changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain on the first page, in the bottom right-hand corner, the effective date. In addition, each time you register we will have copies of the current notice available on request.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Sheila C. Johnson Center for Clinical Services. To file a complaint, you must make your request in writing to the Sheila C. Johnson Center for Clinical Services, P.O. Box 400270, Charlottesville, VA 22904. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

## OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission (an "authorization"). In particular, most uses and disclosures of medical information for marketing purposes, most disclosures in return for payment, and most uses and disclosures of psychotherapy notices would require your authorization. If you request the transmission of any protected health information to a third party you will need to complete a written authorization for each recipient. Authorization forms and instructions are available on the Center's website at education.virginia.edu/research-initiatives/sheila-c-johnson-center-clinical-services/forms-and-resources. Call (434) 924-7034 with any questions, you may revoke authorization, in writing, at any time by contacting the Sheila C. Johnson Center for Clinical Services, P.O. Box 400270, Charlottesville, VA 22904. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

## MORE INFORMATION

If you have any questions you may contact:

Sheila C. Johnson Center for Clinical Services
P O Box 400270
Charlottesville, VA 22904-4270
Phone: (434) 924-7034

## Acknowledgment of Receipt of Notice to Privacy Practices

Please sign and print your name and date on this acknowledgement form. Then return your signed acknowledgement to the Center Receptionist or to the following address:

Sheila C. Johnson Center for Clinical Services
P.O. Box 400270
Charlottesville, VA 22904-4260

CLIENT'S NAME: _____

Check Box to Sign

Signature of Client:_____ ☐

*Or*

Signature of Parent/Guardian (if applicable):_____ ☐

Printed Name of Individual Signing: _____

Date: _____

If you do not have access to a digital signature, please check the box as an indication that you have read and understand this document.