

• THIS COPY IS FOR YOUR RECORDS •

**UC IRVINE-COUNSELING CENTER- NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND
DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

The University of California, including UC Irvine Counseling Center, is a teaching and research institution. Graduate students, fellows and residents may participate in your care as a part of their mental health training programs. All care is overseen and supervised by a licensed mental health professional. All information describing your mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy, too. This Notice also applies to your counselor, psycho-therapist, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

For TREATMENT For example, we may give information about your psychological condition to other health care providers to facilitate your treatment, referrals or consultations.

For PAYMENT For example, we may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.

For HEALTH CARE OPERATIONS For example, we give information to University psychological and medical services staff to review the quality of care

provided, for performance improvement or for the training of health professionals.

For APPOINTMENTS AND SERVICES to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.

To INDIVIDUALS INVOLVED IN YOUR CARE, such as your parents, if you are a minor, or your conservator.

WITH YOUR WRITTEN AUTHORIZATION We may use or disclose mental health information for purposes not described in this Notice only with your written authorization

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION

As REQUIRED BY LAW when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.

For HEALTH OVERSIGHT ACTIVITIES to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

In JUDICIAL PROCEEDINGS in response to court/administrative orders, subpoenas, discovery requests or other legal process.

To PUBLIC HEALTH AUTHORITIES to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.

To LAW ENFORCEMENT for, example, to assist in an involuntary hospitalization process.

To THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES for legislative investigations.

For RESEARCH PURPOSES subject to a special review process, and the confidentiality requirements of state and federal law.

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY of an individual. We may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.

To PROTECT CERTAIN ELECTIVE OFFICERS including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

1. To Receive a Copy of this Notice when you obtain care.
2. To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.
3. To Inspect and Request a Copy of your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.
4. To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing

and give a reason for the request. We may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.

5. To Receive An Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing.

6. To Request That We Contact You By Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on the Counseling Center website: <http://counseling.uci.edu>

CONTACT INFORMATION: If you have any questions about this Notice, please contact the HIPAA Coordinator at the UC Irvine Counseling Center, 201 Student Services I; Irvine, CA 92697-2200 or by telephone at 949-824-6457.

If you believe your privacy rights have been violated, you may file a complaint with the UC Irvine HIPAA Privacy Officer: Marion Mallory, RHIA, CHC Hospital & Privacy Compliance Officer University of California, Irvine 333 City Blvd West, Suite 110, Orange, CA 92868, Phone: 714-456-3674, Fax: 714-456-3679, or with the Secretary of the Department of Health and Human Services.

You will not be penalized for filing a complaint.

Effective Date: September 24, 2007



Counseling Center

201 Student Services I
Irvine, CA 92697-2200
(949) 824-6457 (Office)
(949) 824-6586 (Fax)
www.counseling@uci.edu

**NOTICE OF MENTAL HEALTH PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT**

The UC Irvine Counseling Center Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we will provide you, copies of the current notice are available by accessing our website at <http://counseling.uci.edu>.

I acknowledge that I have received the Notice of Mental Health Privacy Practices.

Signature of Patient or Patient Representative: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

NOTICE OF MENTAL HEALTH PRIVACY PRACTICES-WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

Please document your efforts to obtain acknowledgement by indicating the reason it was not obtained.

- Notice of Mental Health Privacy Practices Given-Patient Unable to Sign
- Notice of Mental Health Privacy Practices Given-Patient Declined to Sign
- Notice of Mental Health Privacy Practices and Acknowledgement mailed to Patient
- Other Reason Patient Did Not Sign. _____

Signature of Counseling Center Representative: _____ Date: _____

Print Name: _____

**THANK YOU FOR PROVIDING THIS INFORMATION.
PLEASE RETURN THIS FORM TO THE RECEPTION DESK.**