Raquel Molina-Ravenna, LCSW

Notice of Privacy Practices

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

I, Raquel Molina-Ravenna, LCSW, understand that health information about you and your healthcare is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from us, which allows me to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this healthcare practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information.

I. OUR PLEDGE REGARDING HEALTH INFORMATION: I am required by law to:
   a. Make sure that protected health information ("PHI") that identifies you is kept private.
   b. Give you this notice of our legal duties and privacy practices with respect to health information.
   c. Follow the terms of the notice that is currently in effect.
   d. Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
   e. I will not use or share your information other than as described here unless you tell me I can in writing. If you tell me I can, you may change your mind at any time. You must let me know in writing if you change your mind.
   f. I can change the terms of this Notice (unless they are required under applicable law), and such changes will apply to all information I have about you. The new Notice will be available upon request and on our website.

II. YOUR CHOICES: For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, please contact us. Tell me

what you want me to do, and I will follow your instructions. In these cases, you have both the right and choice to tell me to:

a. Share information with your family, close friends, or others involved in your care; or
b. Share information in a disaster relief situation;

If you are not able to tell me your preference, for example if I have been persistently unable to reach you through any contact method, I may share your information if I believe it is in your best interest. I may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases, I will never share your information unless you give me advance, written permission:

a. Marketing purposes;
b. Sale of PHI; or
c. Most sharing of psychotherapy notes.

III. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what they mean and will provide examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories:

a. For Treatment, Payment, or Health Care Operations: Federal privacy rules (regulations) allow healthcare providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the healthcare provider's own treatment, payment or healthcare operations. I may also disclose your protected health information for the treatment activities of any healthcare provider. This too can be done without your written authorization. For example, if I were to consult with another licensed healthcare provider about your condition, I would be permitted to use and disclose your PHI, which is otherwise confidential, in order to assist me in diagnosis and treatment of your mental health condition. Disclosures for treatment purposes are not limited to the minimum necessary standard, because healthcare providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the

coordination and management of healthcare providers with a third party, consultations between healthcare providers and referrals of a patient for healthcare from one healthcare provider to another.

b. Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

IV. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

a. Psychotherapy Notes: I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your authorization unless the use or disclosure is:
    i. For my use in treating you.
    ii. For my use in defending Raquel Molina-Ravenna, LCSW in legal proceedings instituted by you.
    iii. For use by the Secretary of Health and Human Services to investigate Raquel Molina-Ravenna, LCSW's compliance with HIPAA or state agencies performing similar functions.
    iv. Required by law and the use or disclosure is limited to the requirements of such law.
    v. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
    vi. Required by a coroner who is performing duties authorized by law.
    vii. Required to help avert a serious threat to the health and safety of others.
b. Marketing Purposes: I will not use or disclose your PHI for marketing purposes, aside from contacting you personally about Raquel Molina-Ravenna, LCSW's services. See Section V(j) below for more information.
c. Sale of PHI: I will not sell your PHI in the regular course of my business.

V. CERTAIN USES AND DISCLOSURES 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:

a. Comply with Law: 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.
b. For Your Own Safety: If I believe that you are a danger to yourself and you threaten to harm yourself, or I otherwise become aware of your serious and imminent intent to harm yourself, or that you are gravely disabled, I may break confidentiality.
c. Help with Public Health and Safety Issues: For public health activities, including reporting suspected child, elder, or dependent adult abuse, neglect, or domestic violence, or preventing or reducing a serious threat to anyone's health or safety as part of my ethical duties to warn and protect.
d. For Health Oversight Activities, including Audits and Investigations: Please note: I may be a mandated reporter under California law. This means that I am mandated to report known or suspected instances of child abuse or neglect, as defined in the Child Abuse and Neglect Reporting Act ("CANRA"), as well as physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder adult or dependent adult. In such cases, I am required to make a report even if I do not obtain your permission to do so. Similarly, if I am acting under my duty to warn and protect, I will not request your permission for authorization before acting.
e. Respond to Lawsuits and Legal Actions: For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so and I will assert therapist-client privilege whenever I can.
f. For Law Enforcement Purposes:, Including reporting crimes.
g. Work With Certain Professionals: To coroners or medical examiners, when such individuals are performing duties authorized by law, or funeral directors when an individual under my care dies.
h. 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.
i. For Specialized Government Functions: Including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or helping to ensure the safety of those working within or housed in correctional institutions. Further, I may disclose your health information to authorized federal officials as required under the Patriot Act. I will only

reveal as much information as is requested. In such cases, I am required to make a report even if I do not obtain your permission to do so, and by law I cannot reveal when I have disclosed such information to the government.

j. 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.

k. 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 healthcare services or benefits that I offer.

VI. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

a. Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your healthcare, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VII. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

a. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask me not to use or disclose certain PHI for treatment, payment, or healthcare operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your healthcare.

b. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full: You have the right to request restrictions on disclosures of your PHI to health plans for payment or healthcare operations purposes if the PHI pertains solely to a health care item or a healthcare service that you have paid for out-of-pocket in full. I will accept the request unless a law requires me to share that information.

c. The Right to Choose How I Send PHI to You: You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

d. The Right to See and Obtain Copies of Your PHI: Other than "psychotherapy notes," you have the right to obtain an electronic or

paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

e. The Right to Obtain a List of the Disclosures I Have Made: You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
f. The Right to Correct or Update Your PHI: If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
g. 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 exercise your rights and make choices about your health information. I will make sure the person has this authority and can act for you before I take any action.
h. The Right to Obtain a Paper or Electronic Copy of this Notice: You have the right to obtain a paper copy of this Notice, and you have the right to obtain a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.
a. File a Complaint if You Feel Your Rights are Violated: You can file a formal complaint if you feel we have violated your rights by contacting us at raquel@raquelpsych.com or 3769 Gleneagles Drive, Tarzana, California 91356. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on March 21, 2024

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

By providing my electronic signature below, you hereby certify that you have read, understand and agree with the terms of this document and understand that your IP address and a date/time stamp will be recorded as your electronic signature.

Signature: _____ Date:_____

Printed Name: _____