Anthony Kagochi, MA, LMHC. of Anthony Kagochi Counseling Services,
Operating in partnership with Transformative Growth Therapy, PLLC.
1011 E Main Ave, Suite 305, Puyallup, WA 98372
WA State Mental Health Counselor License
Credential# LH 60846613
(253)234-4069
Anthony.Kagochi@TransformativeGrowthTherapy.org

HIPAA and Washington State Notice of Privacy Practices EFFECTIVE DATE: 10/10/2024

NOTICE:
I keep a record of the health care services I provide you. You may ask me to see and copy that record. You may also ask me to correct that record. I will not disclose your record to others unless you direct me to do so in writing or unless the law authorizes or compels me to do so. You may see your record or get more information about it at: 1011 East Main Avenue Suite 305, Puyallup 98372. (304) 508-2784.

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements, and insurance policies. This notice applies to all of the records of your care generated by this mental health care 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 am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

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.

Definitions:

Third Party Payor: Any organization, public or private, that pays or insures health care expenses for beneficiaries at the time when they are patients.

Your health record contains personal information about you and your health. State and Federal law protects the confidentiality of this information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical and mental health, or condition, and related health care services. If you suspect a violation of these legal protections, you may file a report to the appropriate authorities in accordance with Federal and State regulations.

How I am permitted to Use and Disclose Your PHI

For Treatment. I may use your protected PHI to provide you with treatment services.

For Payment. I may use and disclose your protected PHI (Name, address, outstanding debt) so that I can receive payment for the treatment services provided to you.

For Healthcare Operations. I may use and disclose your protected PHI for certain purposes in connection with the operation of my professional practice, including supervision and consultation.

Without Your Authorization. State and Federal law also permits me to disclose information about you without your authorization in a limited number of situations, such as with a court order. But I will not disclose without being legally compelled.

With Authorization. I must obtain written authorization from you for other uses and disclosures of your PHI. You may revoke such authorizations in writing in accordance with 45 CFR. 164.508(b)(5).

Incidental Use and Disclosure. I am not required to eliminate ALL risk of an incidental use or disclosure of your PHI. Specifically, a use or disclosure of your PHI that occurs as a result of, or incident to an otherwise permitted use or disclosure is permitted as long as I have adopted reasonable safeguards to protect your PHI, and the information being shared was limited to the minimum necessary.

Examples of How I May Use and Disclose Your PHI
Listed below are examples of the uses and disclosures that I may make of your PHI. These examples are not meant to be a complete list of all possible disclosures, rather, they are illustrative of the types of uses and disclosures that may be made.

1. **Treatment**. Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation or supervision activities with other health care providers, or referral to another provider for health care services.
2. **Payment**. I may use your PHI to obtain payment for your health care services. This may include providing information to a third party payor, or, in the case of unpaid fees, submitting your name and amount owed to a collection agency.

Healthcare Operations. I may use or disclose your PHI (personal identifying information and diagnosis at minimum) in order to support the business activities of my professional practice including; disclosures to others for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to assist in the delivery of health care, provided I have a written contract with the business that prohibits it from re-disclosing your PHI and requires it to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments.

Other Uses and Disclosures That Do Not Require Your Authorization

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples of this type of disclosure include healthcare licensure related reports, public health reports, and law enforcement reports. Under the law, I must make certain disclosures of your PHI to you upon your request. In addition, I must make disclosures to the US Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of privacy rules.

Health Oversight. I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control. If I disclose PHI to a health oversight agency, to the extent I am required by law I will have an agreement in place that requires the agency to safeguard the privacy of your information.

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the initial mandated report.

Deceased Clients. I may disclose PHI regarding deceased clients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Criminal Activity or Threats to Personal Safety. I may disclose your PHI to law enforcement officials if I reasonably believe that the disclosure will avoid or minimize an imminent threat to the health or safety of yourself or any third party.

Compulsory Process. I may be required to disclose your PHI if a court of competent jurisdiction issues an appropriate order, if I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, if required, if no protective order has been obtained, and if a competent judicial officer has determined that the rule of privilege does not apply.

Essential Government Functions. I may be required to disclose your PHI for certain essential government functions. Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a

correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

Law Enforcement Purposes. I may be authorized to disclose your PHI to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, and subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if I suspect that criminal activity caused the death; (5) when I believes that protected health information is evidence of a crime that occurred on my premises; and (6) in a medical emergency not occurring on my premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.

Psychotherapy Notes. I must obtain your authorization to use or disclose psychotherapy notes with the following exceptions. I may use the notes for your treatment. I may also use or disclose, without your authorization, the psychotherapy notes for my own training, to defend myself in legal or administrative proceedings initiated by you, as required by the Washington Department of Health or the US Department of Health and Human Services to investigate or determine my compliance with applicable regulations, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight, for the lawful activities of a coroner or medical examiner or as otherwise required by law. I also reserve the right to withhold these notes from being disclosed when requested as they are not a part of your health record.

Uses and Disclosures of PHI with Your Written Authorization
Other uses and disclosures of your PHI will be made only with your written authorization. I will not make any other uses or disclosures of your psychotherapy notes, I will not use or disclosure your PHI for marketing proposes, and I will not sell your PHI without your authorization. You may revoke your authorization in writing at any time. Such revocation of authorization will not be effective for actions I may have taken in reliance on your authorization of the use or disclosure.

Your Rights Regarding Your PHI
You have the following rights regarding PHI that I maintain about you. Any requests with respect to these rights **must be in writing**. In order to exercise these rights you must request a "TGT ROI" form to be either sent by "Adobe Sign" or sign one in person in office with your identity verified.

Right of Access to Inspect and Copy. You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as I maintain the record. A "designated record set" contains medical and billing records and any other records that I use for making decisions about you. Your request must be in writing. I may charge you a reasonable cost-based fee for the copying and transmitting of your PHI (**See consent for service**). I can deny you access to your PHI in certain circumstances. In some of those cases, you will have a right of recourse to

the denial of access. Please contact me if you have questions about access to your medical record.

Amendments and Restrictions on Your Health Information
In accordance with 42 U.S. Code § 17935, you have important rights when it comes to your protected health information (PHI):

- Right to Request Restrictions: You can request limits on how your PHI is used or disclosed, particularly to health plans for services you've paid for out-of-pocket in full. We are required by law to honor these requests.
- Security of Electronic Health Information: We follow strict security measures, in line with the HITECH Act, to protect your electronic health records from unauthorized access.
- Prohibition on Sale of PHI: Your PHI will never be sold without your explicit consent, unless legally permitted. We ensure your data is not used inappropriately for financial gain.

Right to Amend: You can request changes to your PHI. If we deny your request, you may submit a written statement of disagreement, and we'll provide a rebuttal if necessary.

Right to Request Restrictions on Disclosure: You have the right to ask us not to use or disclose your PHI for certain purposes, including treatment or payment, and to restrict its disclosure to family members involved in your care. While we are not always required to agree to all restrictions, we are happy to discuss them with you.

Right to Request Confidential Communication. You have the right to request to receive confidential communications from me by alternative means or at an alternative location. I will accommodate reasonable written requests. I may also condition this accommodation by asking you for information regarding how payment will be handled or specification of an alternative address or other method of contact. Please contact me if you would like to make this request.

Right to a Copy of this Notice. You have the right to obtain a copy of this notice from me. Any questions you have about the contents of this document should be directed to me.

Right to Opt Out. You have the right to choose not to receive clinical advertisements, such requests must be made in writing

Right to Notice of Breach. You have the right to be notified of any breach of your unsecured PHI. And will be notified in compliance with HIPAA privacy regulations.

Contact Information: I act as my own Privacy and Security Officer. If you have any questions about this Notice of Privacy Practices, please contact me. My contact information is:
Anthony Kagochi, MA, LMHC.
1011 East Main Avenue Suite 305
Puyallup 98372
(253)234-4069
Anthony.Kagochi@TransformativeGrowthTherapy.org

You can also contact my office manager:
Matthew Grotefend (304)508-2784 or by email at:
Matthew@TransformativeGrowthTherapy.org

Complaints: If you believe I have violated your privacy rights, you may file a complaint in writing with me, as my own Privacy Officer, as specified above. You also have the right to file a complaint in writing to the Washington State Department of Health, Health Systems Quality Assurance Division, PO Box 47857, Olympia, WA 98504-7857. You may also call them directly at (360) 236-2620 or access online forms and information at www.doh.wa.gov\hsqa. I will not retaliate against you in any way for filing a complaint.

This notice shall be effective from the date of 10/10/2024
Acknowledgment of Receipt of HIPAA and HITECH Notice of Privacy Practices
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, you have certain rights regarding the use and disclosure of your protected health information (PHI). By signing below, you acknowledge that you have received a copy of our HIPAA and HITECH Notice of Privacy Practices, which details these rights and how we protect your health information.

Acknowledgment of Receipt and Understanding of Privacy Practices
I acknowledge that I have received, reviewed, and understand the Privacy Practices as outlined under HIPAA and the HITECH Act. I have had the opportunity to ask any questions regarding the use and disclosure of my protected health information, and I am satisfied with the explanations provided. I confirm that I am of sound mind, voluntarily participating in this process, and understand that I am personally responsible for my own experience and actions throughout my care.

SIGNED: _____ RELATIONSHIP: _____

DATE: _____