

## **Policies regarding release of and storage of records**

-If your records need to be sent to another professional, we will discuss it together. If you agree to share these records, you will need to sign a release form. This form states exactly what information is to be shared, with whom, and why, and it also sets time limits. You may read this form at any time. If you have questions, please ask me.

-Standard policy for psychologists is to destroy clients' records 6 years after the end of your therapy, or for juveniles, 6 years after termination of treatment (or 3 years after 18<sup>th</sup> birthday; whichever comes last). Until then, I will keep your case records in a safe place. If I must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access. If we do family or couple therapy (where there is more than one client), and you want to have my records of this therapy sent to anyone, all of the adults present will have to sign a release.

-As part of cost control efforts, an insurance company will sometimes ask for more information on symptoms, diagnoses, and my treatment methods. It will become part of your permanent medical record. Please understand that I have no control over how these records are handled at the insurance company. My policy is to provide only as much information as the insurance company will need to pay your benefits.

-If requested, I can provide a treatment summary unless I believe that to do so would be emotionally damaging to the requester. If that is the case, I will be happy to send the summary to another mental health professional that is working with you. There would, however, be an additional charge for this service. In some very rare situations, I may temporarily remove parts of your records before you see them. This would happen if I believe that the information will be harmful to you, but I would discuss this with you first.

-Pursuant to HIPAA, I keep Protected Health Information about patients in two sets of professional records. One set constitutes the Designated Medical Record. It includes information about reasons for seeking therapy, a description of the ways in which problems impact life, a diagnosis, the goals set for treatment, progress toward those goals, medical and social history, treatment history, past treatment records that have been received from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to an Insurance carrier. Except in unusual circumstances that involve danger to self or others or where information has been supplied to me others confidentially, a client may examine and/or receive a copy of the Designated Medical Record, if requested in writing.

-In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designated to assist me in providing the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of conversations, analysis of those conversations, and how they impact on therapy. They also contain particular sensitive information that a client may reveal that is not required to be included in the Designated Medical Record.

-Insurance companies can request and receive a copy of the Designated Medical Record, they cannot receive a copy of Psychotherapy Notes without a separate written, signed authorization. Insurance companies cannot require such an authorization as a condition of coverage nor penalize a client in any way for refusal.

-HIPAA provides patients with several new or expanded rights with regard to their Designated Medical Record and disclosures of protected health information. These rights include requesting I amend the record; requesting restrictions on what information from the Designated Medical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that the client has neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made about policies and procedures recorded in the records; and the right to a paper copy of this Agreement, the attached notice form and my privacy policies and procedures. Dr. Brunner is happy to discuss any of these rights with you. Patients under 18 years of age who are not emancipated their parents should be aware that the law may allow both parents to examine their child's treatment records.