

Notice of Privacy Practices 2026

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.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to your family and friends at your request.

Payment: We may use and disclose your health information to insurance companies to obtain payment for services we provide to you, or at their request.

Healthcare Operations: We may use and disclose your health information within McCarthy Psychotherapy Practice for healthcare operations and clinical care assurance.

Appointment Reminders: We may use and disclose your health information to provide you with a reminder that you have an appointment for treatment at McCarthy Psychotherapy Practice.

As Required By Law: We may use and disclose your health information when required to do so by federal, state or local law.

Threat To Health Or Safety: We may use and disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

The following uses and disclosures will be made only with an authorization from you: Most uses and disclosures of psychotherapy notes, the use of protected health information for marketing and research purposes, and the sale of protected health information. If authorization is given, it may later be revoked in writing.

CLIENT RIGHTS

Inspect and Copy: You can ask to see or get an electronic or paper copy of your medical record or other health information we have about you. Usually, this includes medical and billing records, but does not include any psychotherapy notes. If you request copies, we may charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

Request Restrictions: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request and we may say “no” if it would affect your care.

Request Confidential Communications: You can ask us to contact you in a specific way. We will agree to all reasonable requests.

Copy of this Notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

COMPLAINTS

You can contact us by email or phone if you feel we have violated your rights.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you for filing a complaint.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Please feel free to ask any questions you may have about this notice.

By signing below, I certify:

- That I have read or had this form read and/or explained to me.
- That I fully understand its contents including the risks and benefits of telehealth.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature:

Print Name:

Date: