

## **Health Insurance Portability Accountability Act (HIPAA) Client Rights & Therapist Duties**

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

### **LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

**Kristin Zimmerman LMSW, ACSW \* 269-348-0610  
5985 W. Main St.; STE 821  
Kalamazoo, MI 49009**

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1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Michigan Child Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Michigan Adult Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

## CLIENT RIGHTS AND THERAPIST DUTIES

### Use and Disclosure of Protected Health Information:

- **For Treatment** – I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- **For Payment** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- **For Operations** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

### Patient's Rights:

- **Right to Treatment** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- **Right to Confidentiality** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of \$1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- **Right to Amend** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you

want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.

- **Right to a Copy of This Notice** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- **Right to Choose Someone to Act for You** – 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.
- **Right to Choose** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- **Right to Terminate** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- **Right to Release Information with Written Consent** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

**Therapist’s Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

**COMPLAINTS**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of MI Department of Health & Human Services, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Typed Name & Credential: Kristin Zimmerman LMSW, ACSW Date: \_\_\_\_\_

**Kristin Zimmerman LMSW, ACSW**

**4985 W. Main St.; STE 821**

**Kalamazoo, MI 49009**

**SMS Consent Form**

SMS communication is available if you choose to communicate via text; to do so complete the information below and sign. You may opt out of SMS texting at any time by replying to a current text thread with the word STOP, making a verbal request to do so and/or choosing to opt out below. For detailed information re SMS messaging with KZ see Terms and Conditions.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I agree to receive automated text messages at the phone number above in the context of the client/care relationship with KZ. I understand that by checking the box:

- I agree to receive text messages.
- I can Reply STOP to opt-out.
- I can Reply HELP for support.
- Message and data rates may apply
- Message frequency varies.

I revoke my consent to receive and communicate information related to the client/care relationship via text.

**Sign / Date:**

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## Terms and Conditions for Electronic Communications

**Kristin Zimmerman LMSW, ACSW**

**5985 W. Main St.; STE 821**

**Kalamazoo, MI 49009**

**Effective Date:** 03/01/2025

By opting in to receive SMS messages from Kristin Zimmerman LMSW, ACSW (here and after called KZ) you agree to these Terms and Conditions.

### **SMS Messaging Service**

By providing my phone number, I consent to receive SMS text messages from KZ for appointment reminders, scheduling and general two-way communication about my relationship with KZ. Message and Data Rates may apply.

### **Message Frequency**

You will get more than one message from KZ unless you opt-out. Messaging frequency is based on your individual needs pertaining to your treatment. KZ reserves the right to alter the frequency of messages at any time to increase or decrease the total number of messages. Company and carriers are not liable for delays or undelivered messages.

### **Message and Data Rates**

Message and data rates may apply based on your mobile carrier's terms.

### **Privacy Policy**

Your information will be handled in accordance with HIPPA law. Your rights re confidentiality of treatment can be found on my website: [kzcounseling.org](http://kzcounseling.org) and at your request.

### **Cancellation/Opt-Out Instructions**

You can opt out of receiving SMS messages at any time by replying STOP to any message we send you. After you opt out of text messaging, you will receive one additional message confirming your request has been processed.

### **Help/Customer Support**

Text the word HELP for support. You may also contact KZ directly at 269-348-0610.

### **Liability**

KZ is not responsible for any charges, errors, or delays in SMS delivery or undelivered messages caused by your carrier or third-party service providers.

**Note:** in order to maintain the confidentiality of your PHI I use a secure messaging app called RingRx. SMS messaging via this communication service operates in the same manner as commercially available messaging apps, but with security mechanisms, such as encryption, in place to stop an accidental or deliberate disclosure of PHI.

When using the app, authorized users enjoy the same speed and convenience as SMS or IM text messaging, but cannot send messages containing PHI outside of the communications network, copy and paste data outside the app, or save it to an external storage device. Should there be a duration where the app is inactive, the user is automatically logged off.

All activity on this SMS communication network, RingRx, is monitored and an audit trail is maintained so there is 100% message accountability. If a mobile device onto which this secure messaging app has been downloaded is lost or stolen, any and all communication and content shared can be remotely wiped.