Illuminate Therapy, PLLC
Kristen M. Anderson, MS, LMHC, LPCC
PO Box 48272, Minneapolis, MN 55448
612-456-8337
illuminatepullman@gmail.com

NOTICE OF PRIVACY PACTICES

Effective Date: November 4, 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.

1. My Legal Duties

I am required by applicable federal and state law to maintain the privacy of your Protected Health Information (PHI). PHI is defined as any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with your identity and directly relates to your health care. I am also required to give you this Notice of Privacy Practices about my legal duties, privacy practices, and your rights concerning your PHI. If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices, I cannot treat you. I must follow the privacy practices described in this Notice while it is in effect. In the event of an unauthorized breach of your health information, I will notify you within 30 days of discovering the breach.

2. How I May Use and Disclose Your Protected Health Information.

I have a limited right to use and/or disclose your health information regarding treatment, payment for my services, and business operations. For uses beyond that, I must have your written authorization unless the law permits or requires me to make the use or disclosure without your authorization. If I disclose your health information to an outside entity in order for that entity to perform a function on behalf of myself or my business, I must have in place an agreement from the outside entity that it will extend the same degree of privacy protection to your information that I must apply.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

Treatment: I am permitted to disclose your health information to another person who I reasonably believe is or was involved in your health care, to the extent the recipient needs to know the information. While a separate authorization for Release of Information (ROI) is not legally required under Washington State law, it is my practice

policy to get your verbal confirmation regarding your permission to contact external persons before doing so.

Payment: I do not bill insurance companies directly. For payment purposes, I utilize your health information to create a routine "superbill" containing your required clinical data and diagnosis for you to submit to your insurance company if you choose to seek out-of-network reimbursement. SimplePractice also has the ability to send billing invoices and/or receipts to your email if enabled.

Healthcare Operations: I utilize your health information for internal business management, including interactions with my business associates (i.e. SimplePractice & accountant), clinical peer consultation, scheduling platforms, auditing, and quality assessments. This may include sending electronic information to your email (e.g. telehealth session links, payment links) unless you have provided me with alternative instructions.

3. Exceptions to Confidentiality

Your participation in clinical services, the content of our sessions, and any information I maintain about you is protected by legal confidentiality. However, some exceptions to confidentiality are the following situations in which I may choose to, or be required to, disclose your information:

When required by law: I am required to disclose information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order or valid subpoena. I must also disclose health information to authorities that monitor compliance with these privacy requirements.
For public health activities: I am required to collect information about disease or injury, or to report vital statistics to the public health authority.

For health oversight activities: I may disclose information to agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

Relating to decedents: I may disclose information relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations, or transplants.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, I may disclose information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

For specific government functions: I may disclose protected health information of military personnel and veterans in certain situations, to correctional facilities in certain

situations, to government benefit programs relating to eligibility and enrollment, such as worker's compensation, and for national security reasons, such as protection of the President.

4. Your Rights Regarding Your PHI

You have the following rights relating to your PHI:

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: Under federal law, you have the right to restrict disclosures of your information to health insurance plans if you pay for services entirely out-of-pocket. Because my practice is strictly self-pay, I do not send your records to insurance providers unless you have authorized me to do so.

Right to Request Restrictions: You have the right to request, in writing, that I limit or not disclose your information. While I will consider your request, I may not abide by it if it is unlawful for me to do so or in the case of emergencies.

Right to Revoke: A ROI you sign will remain valid until the specific expiration date or event listed directly on the form, or until you choose to revoke it in writing. Under Washington State law, any ROI to an employer or a financial institution is legally capped and automatically expires after a maximum of one year.

Right to Choose How I Contact You: You have the right to ask that I send you information at an alternative address, or by alternative means. I must agree to your request as long as it is reasonably easy for me to do so. For example, asking me to contact you via the client portal and not phone, or asking for appointment reminders via text and not email.

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of your records. The request must be in writing and a ROI signed. Reasonable copying fees may be charged (*see Professional Disclosure Statement, Clinical Records Fees*). Please make your request well in advance. I respond within 14 working days of receipt of your request. 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 information in your record is incorrect or incomplete, you may request a written amendment. You may also ask for corrections or amendments to your records by explaining in writing why and how you think your records should be changed. I will respond to your request within 10 days of receipt of your request, or deny your request with a formal written explanation.

Right to a Copy of This Notice: If you received this Notice electronically, you have a copy in your client portal and can print it. If you need another copy, please ask me and I can send you another electronic copy or mail you a paper copy.

Right to an Accounting*:* You generally have the right to receive an accounting of disclosures of health information 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.

Right to Psychotherapy Notes: These are notes I take during our session to document or analyze the content of our conversations. They are kept separate from your standard medical record and may not be used or disclosed to a third party without your written consent, except by myself for specific purposes. Washington State law does not permit me to withhold these notes from you.

4. Complaints & Revisions

I reserve the right to change these privacy policies. If I revise my policies and procedures, I will provide you with a revised notice through the client portal for you to review and sign. If you think I have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, please contact me directly. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, or the Washington State Department of Health. I will take no retaliatory action against you if you make such complaints.

U.S. Department of Health and Human Services, Office for Civil Rights
200 Independence Avenue, S.W., Washington, D.C. 20201

1-800-368-1019 · TDD: 1-800-537-7697 · Email: OCRMail@hhs.gov
File a complaint online: https://www.hhs.gov/hipaa/filing-a-complaint/index.html

Washington State Department of Health - Health Systems Quality Assurance
P.O. 47857**,** Olympia, WA 98504-7857
Phone: 360-236-2620 **-** TDD 711 - E-mail:hsqacomplaintintake@doh.wa.gov
File a complaint online: https://doh.wa.gov/licenses-permits-and-certificates/file-complaint-about-provider-or-facility/health-professions-complaint-process

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 Name (Printed): _____Date: _____

Client/Legal Representative Signature: _____