



HIPAA NOTICE OF PRIVACY PRACTICES

David Hoffman, PhD, 1 Mt. Vernon Street, Suite 208, Winchester, MA 01890 (781) 787-2708

Effective Date: 10/1/2025

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW

1. My Commitment to Your Privacy

I am required by law to maintain the privacy and security of your protected health information (PHI). I must follow the duties and privacy practices described in this notice and provide you with a copy of it. I will not use or share your information other than as described here unless you tell me I can in writing. If you give me written permission to use or disclose your information, you may revoke that permission at any time by notifying me in writing, except to the extent that I have already relied on your permission.

2. How I May Use and Disclose Your Health Information

I may use and disclose your health information for the following purposes without your written authorization:

For Treatment: To provide, coordinate, or manage your psychological treatment and related services, including consultation with other health care providers. For example, I might discuss your case with a psychiatrist (with your authorization) to coordinate medication management.

For Payment: To bill for services and collect payment from you, your health plan, or another third party. For example, I may submit claims to your health insurance company with information about your diagnosis and dates of service.

For Health Care Operations: For necessary activities to run my practice, such as quality assessment, clinical training, and administrative services.

3. Disclosures That May Be Made Without Your Authorization

The law permits or requires me to disclose your health information without your authorization in certain circumstances: when required by law (including mandatory reporting of suspected child abuse/neglect, elder abuse, or abuse of individuals with disabilities as required by Massachusetts

law); to avert a serious threat to health or safety if I believe disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or the health or safety of others; for public health activities such as preventing or controlling disease or reporting adverse reactions to medications; for health oversight activities to a health oversight agency for audits, investigations, or licensure actions; for judicial and administrative proceedings in response to a court order, or a subpoena after I verify reasonable efforts have been made to notify you; for law enforcement purposes for specific purposes such as identifying a suspect or reporting criminal conduct at my office; to coroners, medical examiners, and funeral directors; for workers' compensation; for research purposes when reviewed by an institutional review board or with your written authorization; and for specialized government functions such as military and veterans activities or national security.

4. Uses and Disclosures That Require Your Written Authorization

I will not use or disclose your health information for the following purposes without your specific written authorization: psychotherapy notes (see below for limited exceptions); marketing (I do not currently engage in any marketing activities); sale of health information (I will not sell your health information); fundraising (I do not use your health information for fundraising purposes); and any other use or disclosure not described in this notice.

5. Psychotherapy Notes

I maintain psychotherapy notes separately from your clinical record. These are my personal observations recorded for my own use in providing therapy. These notes have additional protections under HIPAA and are not included in the health information available to you under your general right to access. I will not release them without your specific written authorization except in very limited circumstances permitted by law.

6. Your Rights Regarding Your Health Information

Right to Inspect and Copy: You have the right to inspect and obtain a copy of your health information maintained in your clinical record. To request this, submit a written request. I will respond within 30 days (with a possible 30-day extension). I may charge a reasonable, cost-based fee for copying and mailing your records.

Right to Amend: If you believe that information in your record is incorrect or incomplete, you may request that I amend it by making a written request and providing a reason. I will respond within 60 days. I may deny your request if the information is accurate and complete, was not created by me, or is not part of the records I maintain. If I deny your request, you have the right to submit a written statement disagreeing with the denial, which I must include with your records.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures of your health information that I have made in the six years prior to your request. The first accounting you request within a 12-month period will be free. The accounting will not include disclosures for treatment, payment, or health care operations, disclosures made to you, or disclosures you authorized in writing.

Right to Request Restrictions: You may ask me to restrict how I use or disclose your information for treatment, payment, or health care operations, or to family members involved in your care. I am generally not required to agree to your request. However, I must agree to your request if you pay me completely out-of-pocket (not through any health plan) for a specific service and you request that I not share information about that service with your health plan for payment or health care operations purposes.

Right to Request Confidential Communications: You have the right to request that I communicate with you about your health information in a certain way or at a certain location (e.g., only at work, or only by mail). I will accommodate all reasonable requests.

Right to Receive Notification of a Breach: You have the right to be notified if there is a breach of your unsecured health information. I will notify you promptly if such a breach occurs.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice at any time.

Right to Choose a Personal Representative: You have the right to designate another person to act on your behalf (e.g., through a health care power of attorney). I will verify their legal authority before sharing information or accepting instructions.

7. Special Considerations for Minors and Adolescents in Massachusetts

General Principles: In most cases, a parent or legal guardian is the minor's "personal representative" and controls access to the minor's PHI. However, Massachusetts law and professional standards recognize important privacy protections for minors.

When Massachusetts Law May Limit Parental Access: Massachusetts law allows minors to consent independently to certain types of health care (e.g., mental health services for minors age 16 and older in certain circumstances, or treatment for substance use disorders). When a minor has the legal right to consent, they control access to their health information.

When HIPAA May Limit Parental Access: I may deny a parent or guardian access to a minor's health information if I determine that providing access is reasonably likely to endanger the physical safety or life of the minor or another person; the minor obtained services they had the legal right to consent to independently; or a court has specifically limited parental access.

How I Typically Work with Families: I support treatment by communicating with parents/guardians through scheduled parent sessions or phone consultations, updates about attendance, general treatment progress, and goals, and immediate notification of significant safety concerns.

Information Shared with Parents/Guardians (Typically): General updates on treatment progress, goals, and recommendations; information about attendance and engagement in treatment; immediate notification of significant safety concerns; and opportunity for parent sessions or phone consultations.

Information Typically Kept Private: Specific content disclosed in therapy sessions is generally kept confidential, and session-by-session notes and psychotherapy notes are not routinely shared.

Exceptions—When Confidentiality Must Be Limited: I am required or permitted to disclose information without the minor's consent when there is a serious and imminent risk of harm to the minor or others; there is suspected abuse, neglect, or exploitation (mandatory reporting); a court orders disclosure; or the parent/guardian has a legal right to the information and no exception applies.

To ensure the best clinical outcomes, I operate on a model of bounded but open two-way communication with parents. I encourage you to actively share your questions and observations as they arise. This collaborative approach ensures you have the necessary information to partner with me in making informed choices for your child's well-being.

8. Changes to This Notice

I reserve the right to change the terms of this notice and make the new provisions effective for all health information I maintain. If I make a material change, I will promptly post the new notice in my office and on my website and provide you with a copy of the revised notice at your next visit or by mail/email.

9. Questions and Complaints

If you have questions, would like to exercise any of your rights, or want additional information, please contact me at the address and phone number listed at the top of this notice.

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the U.S. Department of Health and Human Services. I will not retaliate against you in any way for filing a complaint. To file a complaint with me, contact me at the address and phone number listed above. To file a complaint with the federal government, contact the U.S. Department of Health and Human Services, Office for Civil Rights, at 1-800-368-1019 or www.hhs.gov/ocr/privacy/hipaa/complaints/.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Dr. David Hoffman's Notice of Privacy Practices for myself or my minor child. I understand that this notice describes how my health information may be used and disclosed and how I can access my health information.

Client/Parent/Guardian Name (print): _____

Signature: _____ **Date:** _____

Relationship to Client (if signing for minor): _____