Notice of Privacy Practices and Policies, *effective March 1, 2026*

AS REQUIRED BY FEDERAL LEGISLATION, THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to all of the paper and electronic records of your care maintained by Michael Clark MD, PhD whether created by Dr. Clark, office staff or records acquired from outside resources such as other clinicians involved in your care and laboratory reports. I am not in network for any health insurer and do not submit insurance claims but this policy is written to allow for assisting out of network claims or future changes in insurance acceptance.

I. Uses and Disclosures of Protected Health Information (PHI)

A. Permissible Uses and Disclosures without your written authorization.

The following categories describe ways that I use and share your confidential information. Confidential information includes Protected Health Information ("PHI" - information that could be used to identify you). Not every use or disclosure in a category is listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

1. ROUTINE SITUATIONS

For Treatment. I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment to coordinate care to the extent they need to know the information.

For Payment. I may use and disclose PHI so that the treatment and services you receive at the practice may be billed and payment may be collected from you, an insurance company or a third party – including a collection agency if necessary. For example, I may give your health plan information about services you received at the practice so your health plan will pay my practice or reimburse you for the services. I may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. I may use and share PHI for administrative functions necessary to run my practice and promote quality care. For example, I may use your information or combine it with other patient information to review the effectiveness of my treatment and services, to evaluate my performance in caring for you, or to make decisions about additional services my practice should offer. Wherever it is practical, I may remove information that identifies you.

I may share information with business associates who provide services necessary to run my practice, such as transcription companies or billing services in the future (none currently). I will contractually bind these third parties to protect your information as I would. Also, I may permit your health plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you.

Communicating with You and Others Involved in Your Care. My practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In certain situations, I may share information about you with a friend or family member of yours who is involved in your care or payment for your care unless you have requested that such disclosures not occur and I have agreed. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. Whenever possible, this person will be identified by you. However, in emergencies or other situations in which you are unable to indicate your preference, I may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

2. SPECIAL SITUATIONS

As Required By Law: I will disclose information about you when required to do so by federal, state or local law. For example, I may release information about you in response to a valid subpoena or for communicable disease reporting.

(1) Health Oversight Activities: including audits, investigations, inspections, and licensure.

(2) For Judicial or Administrative Proceedings: in response to a court order or other lawful processes.

(3) To Avert Serious Threat to your Health or Safety or the health or safety of others

(4) Public Health Risks: including but not limited to

- To prevent or control disease, injury or disability;
- To report child abuse or neglect;
- To report adult and domestic abuse;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

(5) Law Enforcement: In response to a court order, subpoena, warrant, summons or similar process;

- To identify or locate a suspect, fugitive, material witness, or missing person;
- If you are suspected to be a victim of a

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crime, generally with your permission;

- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and,
- In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

(6) Worker's Compensation: If you file a worker's compensation

(7) In the event of Medical Emergency

(8) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.

B. Uses and DISCLOSURES THAT REQUIRE your written AUTHORIZATION

Uses and disclosures other than those descrbedin Section IA above will be made only you're your written authorization. For example, you will need to sign an authorization form before we can send PHI to a school or your attorney. You may revoke any such authorization in writing at any time.

Psychotherapy notes are handled separately under HIPAA and have additional protections. Specifically, the regulations state that in most instances a practice must obtain an authorization for any use or disclosure of psychotherapy notes. No authorization is needed to carry out treatment, payment, or health care operations and the uses listed in routine situations. All other circumstances require a valid authorization from you for use and disclosure.

II. YOUR RIGHTS AS A PATIENT

A. Right to request restrictions on certain uses and disclosures. You have the right to request a restriction or limitation on the use and sharing of information about you for treatment, payment, or health care operations. You must request any such restriction in writing. I am not required to agree to any such restriction you may request.

B. Right to receive confidential communications. You have the right to request that my staff or I communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a post office box. To request confidential communications, you must make your request in writing.

C. Right to inspect and obtain copies. You have the right to review and obtain copies of information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy information that may be used to make decisions about you, you must submit your request in writing. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. Under limited circumstances, I may deny access to your records if I believe the information may be harmful to you or someone else. You have the right to appeal any denials. The appeal will be reviewed by a qualified individual other than myself. I will comply with the outcome of the review.

D. Right to amend confidential information. If you feel that the information I have about you is incorrect or incomplete, you may ask me to amend the information. Your request must be in writing submitted to me, and it must explain why the information should be amended. I may deny your request under certain circumstances.

E. Right to receive an accounting of disclosures of confidential information. Upon request, you may obtain an accounting of certain disclosures of PHI made about you in the last six years, subject to certain restrictions and limitations.

F. Right to receive notification of a breach. We are required to notify you if I discover a breach of your unsecured PHI, according to requirements under federal law.

MY PRACTICE'S DUTIES

In addition to your rights as a patient, my practice has duties to protect your confidential information and inform you of changes to protection measures. I am required by law to maintain the privacy of confidential information and provide you with notice of my legal duties and privacy practices with respect to such information. I am required to abide by the terms of this Notice currently in effect.

CHANGES TO THIS NOTICE

I reserve the right to revise or change provisions on this notice. I will make the new Notice provisions effective for all confidential information I maintain. If I change this Notice, I will post the revised notice in the waiting room. The Notice will contain the effective date on the top of first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

PRIVACY OFFICER

I am the privacy officer for my practice. You may contact me with questions or comments at 206-756-1316 or the address at the bottom of this page.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I am required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice. (See Below.)

Michael Clark MD, PhD.
200 1st Ave W, Suite 400
Seattle WA 98125

Acknowledgement of Receipt of Notice of Privacy Practices

In order to comply with HIPAA standards each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or health care operations.

I have received a copy of the Notice of Privacy Practices from:

Michael Clark MD, PhD.
200 1st Ave W, Suite 400
Seattle WA 98125

Patient Signature: _____ Date: _____

Patient Name _____