HER HAVEN

COUNSELING

Creating space for women to heal, connect & belong.

NOTICE OF PRIVACY PRACTICES

Effective Date: November 5, 2026

PLEASE REVIEW THIS NOTICE CAREFULLY.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

At Her Haven Counseling, protecting your privacy is an important part of providing safe and effective mental health care. This Notice of Privacy Practices describes how I may use and disclose your Protected Health Information (PHI), your rights regarding your health information, and my responsibilities regarding the privacy of your information.

For purposes of this notice, “I,” “me,” and “my” refer to Her Haven Counseling and its treating clinician(s).

YOUR RIGHTS

Receive a copy of your records.

You may request access to your medical and mental health records and may request a copy in paper or electronic form, subject to applicable law.

Request corrections.

You may ask that information in your records be corrected or amended if you believe it is inaccurate or incomplete.

Request confidential communications.

You may ask me to communicate with you about your care in a particular way or at a particular location. I will consider reasonable requests.

Request restrictions.

You may ask me to limit how I use or disclose your health information. I am not required to agree to every request, except where required by law.

Request an accounting of certain disclosures.

You may request a list of certain disclosures of your health information made during the six years before your request, subject to legal limitations.

Receive a copy of this Notice.

You may request a paper copy of this notice at any time, even if you have agreed to receive it electronically.

Choose someone to act on your behalf.

If you have a legally authorized personal representative, that person may exercise certain rights on your behalf, subject to verification of their authority.

File a complaint.

You may file a complaint with Her Haven Counseling or with the U.S. Department of Health and Human Services Office for Civil Rights if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

HOW YOUR INFORMATION MAY BE USED AND DISCLOSED

I may use or disclose your PHI without your written authorization when permitted or required by law, including for the following purposes:

Treatment

I may use or disclose your information to provide, coordinate, or manage your mental health treatment. For example, I may communicate with another health care provider involved in your care when permitted by law.

Payment

I may use or disclose your information as necessary to obtain payment for services. For example, if you use health insurance, I may provide information to your health plan for purposes such as determining eligibility, obtaining payment, or processing a claim.

Health Care Operations

I may use or disclose your information as necessary to operate my practice and maintain the quality and safety of services. Examples may include billing, quality assessment, compliance activities, credentialing, and other activities permitted by law.

As Required by Law

I may use or disclose your information when required to do so by federal, state, or local law.

Serious Threats to Health or Safety

I may disclose information when permitted by law if necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another person.

Abuse, Neglect, or Domestic Violence

I may disclose information when required or permitted by law to report suspected abuse, neglect, or domestic violence.

Judicial and Administrative Proceedings

I may disclose information when required or permitted by applicable law in response to a court or administrative order or other lawful process.

Law Enforcement

I may disclose information to law enforcement when permitted or required by applicable law.

Public Health Activities

I may disclose information for certain public health activities as permitted or required by law.

Workers' Compensation

I may disclose information as necessary to comply with workers' compensation laws.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

Most uses and disclosures of psychotherapy notes require your written authorization unless an exception under federal law applies.

Other uses and disclosures of your PHI that are not described in this notice or otherwise permitted or required by law will generally require your written authorization.

You may revoke an authorization in writing at any time, except to the extent action has already been taken based on that authorization.

Her Haven Counseling does not sell your PHI and does not use your PHI for marketing purposes without your written authorization when such authorization is required by law.

YOUR CHOICE REGARDING FAMILY AND FRIENDS

Unless you object, I may disclose limited information to a family member, close personal friend, or another person you identify as being involved in your care or payment for your care when permitted by law.

You may request that I not share information with a particular person.

ELECTRONIC COMMUNICATIONS

Her Haven Counseling may communicate with you electronically, including by email, text message, telephone, or through a secure client portal, when appropriate and permitted by law.

Electronic communication may involve privacy or security risks. You may request alternative methods of communication.

I will use reasonable safeguards to protect your information.

TELEHEALTH

If you participate in telehealth services, your information will be handled in accordance with applicable privacy and security requirements. You should participate in telehealth sessions from a private location whenever possible.

GROUP THERAPY

If you participate in group therapy, Her Haven Counseling will take reasonable steps to protect your privacy. However, information shared during group therapy may be heard by other participants. Unlike Her Haven Counseling, other group members are not subject to HIPAA.

Participants will be asked to respect the privacy of other group members and not disclose information shared during group sessions.

SUBSTANCE USE DISORDER RECORDS

Certain records related to substance use disorder treatment may receive additional federal protections under federal law, including 42 CFR Part 2. When applicable, Her Haven Counseling will comply with those additional requirements.

BREACH NOTIFICATION

If a breach occurs that compromises the privacy or security of your protected health information, I will provide notification as required by applicable law.

MY RESPONSIBILITIES

Her Haven Counseling is required by law to:

- Maintain the privacy and security of your PHI.
- Provide you with this Notice of Privacy Practices.
- Follow the privacy practices described in the notice currently in effect.
- Notify you if a breach occurs that may have compromised the privacy or security of your information.
- Follow applicable federal and state privacy laws.

I reserve the right to change this notice. If material changes are made, the updated notice will be made available upon request and posted on the Her Haven Counseling website.

QUESTIONS OR PRIVACY COMPLAINTS

If you have questions about this notice or believe your privacy rights have been violated, you may contact:

Her Haven Counseling
Privacy Contact: Hannah Richins, CMHC
Phone: [PHONE NUMBER]
Email: [EMAIL ADDRESS]
Address: [BUSINESS ADDRESS]

You may also file a complaint with:
U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: 1-877-696-6775

You may also submit a complaint through the HHS Office for Civil Rights website.

You will not be retaliated against for filing a privacy complaint.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received or been offered a copy of Her Haven Counseling's Notice of Privacy Practices.

Client Name: _____

Client Signature: _____ Date: _____

If signed by a personal representative:

Representative Name: _____ Relationship/Authority: _____

Representative Signature: _____ Date: _____