

# Notice of Privacy Practices



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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## 1. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information.

I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

## 2. USES AND DISCLOSURES WITHOUT YOUR AUTHORIZATION.

The following categories describe different ways that I use and disclose health information that does not require prior authorization from you:

- **For Treatment.** I may use and disclose your medical information to provide, coordinate, and/or manage your treatment, health care, and to recommend new or additional treatments to you.
- **Payment.** I may use and disclose your medical information as-needed to bill or obtain payment for treatments and services provided.
- **Healthcare Operations.** I may use or disclose your medical information to carry out my general or certain business activities, such as training/education, assessment/improvement activities, risk management, claims management, legal consultation, licensing, and other business planning activities.
- **Third Parties.** I may use or disclose your medical information to third parties with whom I have contracted to perform services on my behalf. When your information is disclosed under these circumstances, it will be safe-guarded. When required by law, I may use or disclose your medical information to other third parties, including

government and regulatory entities.

- **Coroners, Medical Examiners, and Funeral Directors; Organ and Tissue Donations.** I may disclose medical information consistent with applicable law to coroners, medical examiners, funeral directors, groups that handle tissue and organ donations, and other medical professionals only to the extent necessary to assist them in carrying out their duties, or to help facilitate organ or tissue donations or transplant.
- **Worker's Compensation.** I may disclose your medical information as authorized by law to comply with worker's compensation laws and similar programs.
- **Law Enforcement; Judicial and Administrative Proceedings; and to Avert a Serious Threat.** I may disclose your medical information when required due to the issuance of a subpoena, warrant, or other court-ordered disclosure, or when required to prevent serious and imminent threat of harm to you or another person, or for the safety of the public, or when otherwise required due to ongoing legal or administrative action.
- **Military, Veterans, National Security, and Other Government Purposes.** If you are a member of the US armed forces, I may release your medical information as required by military command or the Department of Veteran's Affairs. I may also disclose your medical information to authorized federal officials for intelligence and national security purposes, to the extent authorized by law.

### 3. USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION.

I must seek your authorization in order to use or disclose your medical information for any purposes described below, and for any other purposes not set forth in this Notice. This includes authorization to disclose your information for marketing purposes, disclosure of your medical information that constitutes sale of that information, and most uses and disclosures of private therapy notes. You may revoke your authorization in writing at any time, except to the extent I have already taken action in reliance on a prior authorization from you. It is not my practice to sell patient information, or to use patient information in marketing materials.

I must seek your authorization prior to disclosing I may provide your PHI to a family member, friend, or other person whom you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

### 4. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

- **To Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
- **To Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
- **To Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
- **To See and Get Copies of Your PHI.** Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

- To Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
- To Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
- To Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on OCTOBER 27, 2025.

Acknowledgement of Receipt of Privacy Notice: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

**BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Printed Name