

You Belong Integrative Mental Wellness LLC
645 E Pittsburgh Street, PMB #263, Greensburg, PA 15601
Phone: (412) 213-8381 | Email: hello@youbelongimw.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOU MAY HAVE ADDITIONAL RIGHTS UNDER STATE AND LOCAL LAW. PLEASE SEEK LEGAL COUNSEL FROM AN ATTORNEY LICENSED IN YOUR STATE IF YOU HAVE QUESTIONS REGARDING YOUR RIGHTS TO HEALTHCARE INFORMATION.

EFFECTIVE DATE OF THIS NOTICE: May 18, 2026

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (hereafter, "HIPAA"), you have certain rights regarding the use and disclosure of your protected health information (hereafter, "PHI").

I. MY PLEDGE REGARDING YOUR HEALTH INFORMATION

I understand that your health information is personal. I am committed to protecting it. I create a record of the care and services you receive from me as your Psychiatric Mental Health Nurse Practitioner (PMHNP-BC). I need this record to provide you with quality psychiatric care and to comply with certain legal requirements. This notice applies to all records of your care generated by this practice. It will tell you how I may use and disclose your health information, describe your rights regarding that information, and outline my obligations.

I am required by law to:

- Keep your PHI private and secure.
- Provide you with this notice of my legal duties and privacy practices.
- Follow the terms of the notice currently in effect.
- Notify you if I change the terms of this Notice. Changes will apply to all information I have about you. The updated Notice will be available upon request and on my website at youbelongimw.com.

II. HOW I MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe the ways I use and disclose your health information. Not every use or disclosure in a category will be listed; however, all permitted uses and disclosures will fall within one of these categories.

For Treatment, Payment, or Health Care Operations: Federal privacy rules allow health care providers who have a direct treatment relationship with a patient to use or disclose PHI without written authorization to carry out treatment, payment, or health care operations. For example, I may consult with another licensed health care provider regarding your condition, share information for referral purposes, or use your PHI for appointment reminders and billing. Because psychiatric nurse practitioners and other health care providers require access to the full record and complete information to provide quality psychiatric evaluation and medication management care, disclosures for treatment purposes are not limited to the minimum necessary standard. The term "treatment" includes the coordination and management of care with third parties, consultations between providers, and referrals.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, I may disclose health information in response to a court or administrative order, subpoena, discovery request, or other lawful process — but only after efforts

have been made to notify you or to obtain a protective order.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION

1. Psychiatric and Clinical Notes. I maintain psychiatric and clinical notes as defined under 45 CFR § 164.501. Any use or disclosure of such notes requires your written Authorization unless the use or disclosure is:

- For my use in treating you.
- For my use in training or supervising mental health practitioners.
- For my use in defending myself in legal proceedings initiated by you.
- For use by the Secretary of HHS to investigate HIPAA compliance.
- Required by law and limited to the requirements of such law.
- Required for certain health oversight activities.
- Required by a coroner performing duties authorized by law.
- Required to help avert a serious threat to health or safety.

2. Marketing Purposes. I will not use or disclose your PHI for marketing purposes without your prior written consent. If I request a review from you and intend to share it publicly, I will provide a HIPAA authorization form regardless of whether the review appears to contain PHI. You may withdraw consent at any time in writing via email or certified mail. Upon receipt, I will remove your review from all locations under my control. I cannot guarantee removal by third parties who may have copied it.

3. Sale of PHI. I will not sell your PHI under any circumstances.

IV. USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION

Subject to certain legal limitations, I may use and disclose your PHI without Authorization for the following purposes:

- Appointment reminders, treatment alternatives, and health-related services or benefits I offer.
- When required by state or federal law, limited to the relevant legal requirements.
- For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing a serious threat to health or safety.
- For health oversight activities, including audits and investigations.
- For judicial and administrative proceedings, including responding to a court order or subpoena. My preference is to obtain your Authorization first when permitted.
- For law enforcement purposes, including reporting crimes occurring on my premises.
- To coroners or medical examiners performing duties authorized by law.
- For research purposes, including studying and comparing outcomes of psychiatric treatment approaches.
- For specialized government functions, including military missions, protection of the President, intelligence operations, or safety of those in correctional institutions.
- For workers' compensation purposes, in compliance with applicable laws. My preference is to obtain your Authorization first.
- For organ and tissue donation requests.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOUR OPPORTUNITY TO OBJECT

Disclosures to Family, Friends, or Others: You have the right to tell me that I may share your PHI with a family member, friend, or other person involved in your care or payment for your care, or in a disaster relief situation. In

emergency situations involving a serious and immediate threat to health or safety, consent may be obtained retroactively.

VI. YOUR RIGHTS WITH RESPECT TO YOUR PHI

1. **Right to Request Limits on Uses and Disclosures.** You may ask me not to use or disclose certain PHI for treatment, payment, or health care operations. I am not required to agree, and may decline if I believe it would negatively affect your care.

2. **Right to Request Restrictions for Out-of-Pocket Expenses.** If you have paid for a service entirely out-of-pocket, you have the right to request that I not disclose related PHI to your health plan for payment or operations purposes.

3. **Right to Choose How I Contact You.** You may ask me to contact you in a specific way (e.g., a specific phone number or email) or to send correspondence to a different address. I will honor all reasonable requests.

4. **Right to Access Your PHI.** You have the right to obtain an electronic or paper copy of your medical record and related information. I will provide a copy or summary within 30 days of your written request. A reasonable cost-based fee may apply.

5. **Right to an Accounting of Disclosures.** You may request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or operations. I will respond within 60 days. The list covers the last six years. The first request per year is free; subsequent requests may incur a reasonable fee.

6. **Right to Correct or Update Your PHI.** If you believe your PHI contains an error or omission, you may request a correction. I may deny the request but will provide a written explanation within 60 days.

7. **Right to a Paper or Electronic Copy of This Notice.** You have the right to receive this Notice in paper or electronic form at any time, even if you previously agreed to receive it electronically.

8. **Right to Choose an Authorized Representative.** If you have granted someone medical power of attorney or designated a legal guardian, that person may make decisions regarding your health information on your behalf.

9. **Right to Revoke an Authorization.** You may revoke any authorization you have provided to me in writing at any time, except where I have already acted in reliance on it.

10. **Right to Opt Out of Communications.** You have the right to opt out of non-essential communications and any fundraising outreach from this practice.

11. **Right to File a Complaint.** If you believe I have violated your privacy rights, you may contact me directly using the information at the top of this notice, or file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue S.W., Washington, D.C. 20201, by calling (877) 696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you for filing a complaint.

VII. CHANGES TO THIS NOTICE

I reserve the right to change the terms of this Notice at any time. Any changes will apply to all health information I maintain about you. The updated Notice will be available upon request via email at hello@youbelongimw.com and on my website at youbelongimw.com.