



NOTICE OF PRIVACY PRACTICES

PORTLAND MENTAL WELLNESS | RYAN GRASSMANN, .MA. | COUNSELOR, LPC REGISTERED INTERN
1235 SE DIVISION STREET, SUITE 207 | PORTLAND, OREGON 97202
[503] 505.9672 | HELLO@PORTLANDMENTALWELLNESS.COM

NOTICE OF PRIVACY PRACTICES

This notice provides information regarding disclosures of your Protected Health Information (PHI). Portland Mental Wellness is required to notify clients of legal obligations, duties, and practices involving the protection of and the risks to your PHI. Portland Mental Wellness reserves the right to change these privacy practices and will notify you should changes be made. Portland Mental Wellness will not use or disclose your PHI for any purposes other than the exception of the circumstances listed below.

REGISTERED INTERN UNDER SUPERVISION

Ryan Grassmann, M.A., sole owner of Portland Mental Wellness Group LLC is a Registered Intern of the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT). While providing pre-licensed professional psychotherapy services Ryan Grassmann, M.A., LPC Registered Intern is required to practice under the supervision of Margaret Eichler Ph.D., LPC, ACS. Twice monthly at a minimum, meetings are held to discuss clinical cases with Dr. Eichler. At times, other pre-licensed professionals will attend these meetings. All PHI is held in strict confidence during these supervision meetings. Attendance of other pre-licensed and licensed professional meetings also occur regularly. All meetings and consultations occur for the purposes of seeking and providing clinical consultation as a means of improving clinical outcomes.

MANDATED REPORTING

- If there is reason to believe that there is serious and imminent risk to yourself or another person LPC Registered Interns are mandated by law to intervene by reporting the circumstances to the authorities.
- If there is reason to believe that the abuse of a child has occurred, LPC Registered Interns are mandated by law to intervene by reporting the circumstances to the appropriate authorities.
- If there is reason to believe that the abuse of an senior citizen, a mentally ill citizen, or a developmentally disabled citizen has occurred, LPC Registered Interns are mandated by law to report the circumstances to the appropriate authorities.
- LPC Registered Interns are obligated to provide your PHI upon request to organizations responsible for overseeing compliance with governmental rules and standards for providing healthcare.
- Should the receipt of a court order, subpoena, warrant, summons or similar process occur, LPC Registered Interns are obligated by law to provide the requested material.
- LPC Registered Interns may disclose your PHI if there is reason to believe that there is risk to public health and safety.
- LPC Registered Interns may disclose your PHI to a coroner or medical examiner in the case of your death.
- LPC Registered Interns may disclose your PHI in the case of a request from the Workers Compensation Administration.
- In the case of a medical emergency LPC Registered Interns may disclose your PHI to the extent required to deliver appropriate

medical care.

YOUR PRIVACY RIGHTS

- You have the right to request restrictions to your PHI. Requests need to be written. Your therapist will consider such requests however please note that LPC Registered Interns are not obligated to agree to such requests.
- You have the right to receive confidential communications from Portland Mental Wellness. Please discuss your concerns with your therapist either verbally or in writing.
- You have the right to inspect and copy your PHI from Portland Mental Wellness at any time. There are limited circumstances where Portland Mental Wellness may deny such requests.
- You have the right to request that I amend your PHI for as long as your PHI is maintained on record. There are limited circumstances where Portland Mental Wellness may deny such requests.
- You have the right to receive an accounting of disclosures made within the past six years.
- You have the right to obtain a paper copy of this notice upon request.

I have read and understand this privacy notice. I have been provided the opportunity to review this document with my therapist. By signing below I agree to proceed with therapy having considered the risks and limitations to my privacy and confidentiality.

PRINTED NAME
