Cecilia Escobedo, LMFT
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541-514-6019

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY.

I am required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to provide confidentiality of all mental health records and other individually identifiable health information provided to Cecilia Escobedo.

Ways in which I may use and disclose your protected Health Information:

I may use and disclose at my discretion your mental health records for each of the following purposes only: **treatment, payment and health care operations.**

- Treatment means providing, coordinating or managing mental health care and related services.
- Payment means activities such as obtaining payment for the mental health care services I provide for you from your insurance or another third-party payer.
- Health care operations include the business aspects of running a practice.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care.

I will use and disclose your protected health care information when required by federal, state or local law. There are certain situations in which as a mental health therapist I am required by ethical standards to reveal information obtained during psychotherapy to persons or agencies even if you do not give permissions. These situations are as follows: if you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65), I am required by law to inform the appropriate child welfare or social agency with may then investigate the matter; if I am required by court of law (court order) to turn over records to the court of if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked by you. You may revoke authorization in writing and I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand my operation use of information for treatment, payment and health care operations as stated above. A copy of this form has been provided for your own records.

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Signature Name Date