

Notice of Privacy and Confidentiality Practices

PLEASE READ THIS DOCUMENT BEFORE SIGNING.

I am required by law to maintain the privacy and security of your protected health information. I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. I have in place safeguards for your personal information. These safeguards help to meet both federal and state requirements to protect your protected health information.

Discussions between a therapist and a client are confidential. No protected health information will be released without the client's written consent, unless as mandated by law. Where state and federal laws differ, I comply with the stricter standard to ensure that your right to confidentiality is respected at all times. Possible exceptions to confidentiality include but are not limited to the following situations: to help with public health and safety issues such as preventing or reducing a serious threat to anyone's health or safety; to respond to lawsuits and legal actions in response to a court or administrative order or a subpoena; the filing of a complaint with a licensing board or other state or federal regulatory authority; or to comply with the law including the Department of Health and Human Services if it wants to see that I am complying with federal privacy law.

Due to the client-therapist confidential relationship, you understand and agree that no audio and/or visual recording will be made by you or me during the session(s), unless with the prior written consent of both parties. However, there is a security video monitoring system in place to protect you and me; you may be seen but not heard.

Occasionally, I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context, without using your name or protected health information.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-5. There is a copy in my office that I will be glad to let you see to learn more about your diagnosis, if applicable.) Sometimes I have to provide additional clinical information such as treatment plans or summaries, or in rare cases, copies of the entire record. This information will become part of the insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is out of my exclusive control. In some cases, they may share the information with a national medical information databank. If you pay with insurance and have authorized the release of your medical or other information necessary to process an insurance claim assigned to me and sign this agreement, then you agree that I can provide requested information to your insurance carrier.

The State of Texas requires me to file a report in the following cases: (a) if a person is a danger to himself/herself or to others, I will make a report to inform medical and/or law enforcement personnel; and (b) if a person reports abuse, neglect or exploitation of a child, elderly person or a disabled person, I will make a report to inform medical and/or law enforcement personnel. Please

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note that it is not optional for a therapist to try to determine how probable a threat may be before making a report.

In the event that your information is disclosed pursuant to Texas Law, you acknowledge that you have been advised by me of the potential of the re-disclosure of your protected health information by the authorized recipients, and that it will no longer be protected by HIPAA.

I will follow the duties and privacy practices described in this notice and if you desire, give you a copy of it. I will not use or share your information other than described here unless you give me prior written permission to do so. You may change your mind at any time; however, you must let me know in writing that you have changed your mind. You also understand that the cancellation of this authorization will not take effect until Linda Brown, LPC receives an authorization cancellation form from you, and will not affect any actions taken in reliance on this authorization before the receipt of the authorization cancellation form.

If you have any questions regarding confidentiality, you should bring them to my attention at any time during our work together.

I will provide you with a copy of the HIPAA Notice, and you acknowledge that you have received a copy of the HIPPA Notice.

By signing this form, you are giving your consent to me to share confidential information with all persons mandated by law, and with the insurance carrier responsible for providing your mental health care services and payment for those services. You may revoke this in writing at any time. You acknowledge that the treatment provided to you by Linda Brown, LPC (L. Brown LPC, PLLC) was conditioned on you providing this consent. Further, by signing this form, you are also releasing and holding me harmless from any disclosure in accordance with your consent.

x: _____
Client's Signature

Client's Name *(please print)*

Date: _____