HIPAA – Notice of Privacy

Effective November 1, 2013:

The following notice is an introduction to your rights and responsibilities as a client of counseling services. This notice, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA),

"This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully."

I am required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

How I Protect Your Health Information

All of your health information that I collect is confidential.
Access to your health information is restricted to those clinical staff that needs to know your health information in order to provide services to you.
Physical, electronic, and procedural safeguards which comply with federal and state regulations guard your health information.
I maintain records of client health information in a confidential, locked file system. The client files remain the property of my practice, but the information belongs to you.

Voluntary Release of Health Information

I may disclose information to outside treatment or healthcare providers with your written authorization. You may revoke such authorizations at any time provided each revocation is in writing.
I may use your information to develop accounts receivable information and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

Mandatory Disclosures With Neither Consent Nor Authorization

I may disclose your mental health information without your consent or authorization in the following circumstances:

Abuse – If I have reason to believe that a minor child, elderly person, or person with a disability has been abused, abandoned, or neglected, I must report this concern to the appropriate authorities.

Judicial and Administrative Proceedings as Required – If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof, I may be compelled to provide the information. I will not release your information without attempting to notify you or your legally appointed representative.

Injury to Self or Others – If you communicate to me an explicit threat of imminent

physical harm to yourself or others, I have a legal duty to take the appropriate measures, including disclosing information to the police.

Client's Rights:

   • **Rights to Request Restrictions** -You have the right to request additional restrictions on certain uses and disclosures of protected health information. I may not be able to accept your request, but if I do, I will uphold the restriction unless it is an emergency.

   • **Right to Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of mental health information by alternative means and at alternative locations. (For example, you may not want a family member to know you are being seen by a counselor. On your request, I will send your information to another address).

   • **Right to Inspect and Copy** – You have the right to inspect or obtain a copy of your clinical records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. On your request, I will discuss with you the details of the request and denial process.

   • **Right to Amend** – You have the right to request in writing an amendment of your health information for as long as the mental health information records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, I will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.

   • **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of mental health information. If your mental health information is disclosed for any reason other than treatment or health operations, you have the right to an accounting for each disclosure of the previous six (6) years, but the request cannot include dates before August 1, 2009. The accounting will include the date, name
of person, or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

   • **Electronic Information** Requests for client mental health information for the purpose of consultation are honored through phone and postal mail communication only.

   • **Grievance:** should you have a complaint, you have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with me or to obtain additional information, please contact me.

INFORMED CONSENT/HIPAA PRIVACY POLICY ACKNOWLEDGEMENT

Please provide the information requested below. Your signature will indicate that you understand and accept the information contained in the above document "Informed Consent Information", and that you have received a copy of the HIPAA Privacy Policy and a copy of the Informed Consent.

This acknowledges that I have read the HIPAA Privacy Form and Informed consent and have been given a copy for my files.

_____
Printed Name

_____   _____
Signature   Date

_____   _____
Therapist Signature   Date