

NOTICE OF PRIVACY PRACTICES

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

I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPPA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosure of confidential information that may be made and of your individual rights and my legal duties with respect to confidential information.

Notice in Which I May Use and Disclose Your Protected Health Information

I may use and disclose at our discretion your medical/mental health records for each of the following purposes only: treatment, payment and health care options.

- **Treatment** means providing, coordinating or managing mental health care and related services. For example – use or disclosure by the health care provider in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice to improve their skills in group, joint, family or individual counseling.
- **Payment** means activities such as obtaining payment for the mental health services I provide for you either from your insurance or another third-party payer. For example – I may include information with a bill to a third-party payer that identifies you, your diagnosis and procedures performed.
- **Health care operations** include the business aspects of running my practice. For example – to evaluate my treatment and services.

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 your care or payment for your care. For example – a family member, relative, close friend, pastor or pastor's representative with whom you have asked me to communicate.

I will use and disclose your protected health information **when required by federal, state or local law**. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to other persons or agencies – even if you do not give permission. These situations are as follows: (a) 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; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or 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. You may revoke an authorization in writing and we are 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 operational use of your information for treatment, payment and health operations as stated above.

Signature of Client/Responsible Party

Date