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HIPPA NOTICE OF PRIVACY PRACTICES

Effective May 1, 2008

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
I have a duty to maintain privacy of your health information and to provide you with this notice. You will be asked to sign a Consent Form. Once you have signed the Consent Form, I may use or disclose your Protected Health Information (PHI) for purposes of treatment and coordination of care.

The following are permitted and required uses and disclosures that may be made without your consent, authorization or opportunity to object:
Abuse or Neglect: If I suspect abuse or neglect of a child, elder, or vulnerable adult, I am mandated to make a report to the appropriate authorities.
Danger: If I suspect you are in imminent danger of harming yourself or someone else, I am mandated to make a report to the person at risk and to the public authorities.
Legal Proceedings: I may disclose Protected Health Information in response to a court order or subpoena or in certain other legal proceedings.

You have the following rights regarding health information I maintain about you:
Right to Inspect and Copy: You have the right to inspect and request copies of information that may be used to make decisions about your care. Psychotherapy notes, if requested, may be summarized and not directly photocopied when necessary in order to protect the best interest of the client. To inspect and/or receive copies of information, you must submit a request in writing. If you request a copy of information, I may charge a fee for the cost of coping, mailing or other supplies associated with your request. I must respond to your request within fifteen days of receipt.
Right to Amend: If you feel that health information about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by me. Your request for amendment must be in writing and must provide a reason supporting your request.
Right to Request Restriction of Uses and Disclosures: You may request that disclosure of confidential information be limited. If I am unable to agree to that restriction, we can discuss other options, such as referral to another counselor.
Right to Limit Reception of Confidential Information: You have the right to restrict contact, messages, email, etc. from this office and myself by requesting such restriction and to which forms of communication this will apply. For example, you may ask that no messages be left at a work number but state that they may be left at home.
Right to a Paper Copy of this Notice. You have the right to a copy of this notice at any time you request it. A copy will be provided prior to your first visit.
Other uses and disclosures of Protected Health Information and any disclosure of Psychotherapy Notes will be made only with your written authorization. After such authorization is given, you may revoke that authorization at any time.

This Notice may be amended as needed to comply with federal, state and professional requirement. If you believe your privacy rights have been violated, please let me know either in writing or by talking with me.

_____ _____
Signature of Client Date

_____
Printed Name of Client