

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and the limits of confidentiality.

Protecting your privacy and your medical information is very important to us. We recognize our obligation to keep your information secure and confidential whether on paper or electronically. Privacy is one of our highest priorities.

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care and respect. Our clinic employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. This is referred to as using your PHI or Protected Healthcare Information for treatment, payment, or healthcare operations. We may also access information about you when considering a request from you, or when exercising our rights under the law or through any agreement with you. We safeguard all information per established security standards and procedures.

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate, or not current, please inform us. We will take appropriate steps to correct any erroneous information as quickly as possible.

We limit who receives information and what type of information is shared. To help us offer you services we may share information with insurance companies or managed care organizations for claims processing and authorization. Additionally, we may share your information with agencies involved in card processing (limited to demographic information and dates of service for receipts) or assessment companies that provide Psychological Assessments. These companies act on our behalf and are obligated contractually to keep the information we provide to them confidential. Any other patient-specific data is released only when required to provide a service for you and must include a separate signed consent by you. Data is then released with the condition that the person receiving the information will not release it further, unless you give permission. The only exceptions are those in the Limits of Confidentiality section.

I have read and understand the above privacy practices.

Client Signature _____ Date: _____

Guardian Signature _____ Date: _____

Electronic signature at the end of the document will be considered as binding as in-person signature for all documents.

Patient Rights and HIPAA Authorization

The following specifies your rights about authorizations to release Protected Healthcare Information or PHI under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

- Tell your mental health professional if you don’t understand the authorizations, and they will explain it to you.
- You have the right to revoke or cancel an authorization at any time, except (a) to the extent information has already been shared based on the authorization; or (b) the authorization was obtained as a condition of obtaining insurance coverage for treatment. To revoke or cancel an authorization, you must submit a request in writing to your mental health professional and your insurance company, if applicable.
- You may refuse to sign an authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment or affect your eligibility for benefits. If you refuse to sign an authorization, and you are in a research – related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
- Once the protected health information leaves this office per terms of the authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
- If this office initiated the authorization, you must receive a copy of the signed authorization.
- Special Instructions for completing authorizations for the use and disclosure of Psychotherapy Notes: HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” All Psychotherapy notes recorded on any medium (i.e., paper, electronic) by a mental health professional must be kept by the author and filed separate from the rest of the individual’s medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual’s medical records. Excluded from the “Psychotherapy Notes” definition is the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and prognosis to date.

For a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign the authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

I have read and understand the above information.

Client Signature _____ Date: _____

Guardian Signature _____ Date: _____

Electronic signature at the end of the document will be considered as binding as in-person signature for all documents.