Notice of Privacy Practices & Statement of Client Rights

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. A copy of this statement is always available upon request. All information revealed by you in a counseling session and most information placed in your file (all medical records or other individually identifiable health information held or disclosed in any form[electronic, paper, or oral] is considered "protected health information" by HIPAA). As such, your protected health information ***cannot be distributed to anyone else without your express informed or voluntary written consent or authorization.*** With the exceptions described below, you have a legal and ethical right to confidentiality. Your therapist cannot and will not disclose any information regarding you or your treatment to anyone, except her supervisor or peer consult group, without your written consent. Under the provision of the 1992 Health Care Information Act, your therapist may legally speak to another health care provider or family member without your prior consent in emergency situations. The exception to needing a release of information to share information are defined immediately below.

Use or disclose of the following protected health information <u>does not require</u> your consent of authorization:

1. A court order, issued by a judge, could require us to release information contained in your records, or could require a therapist to testify.
2. If you pose a threat of harm to yourself, to another person, or to the community, we will take whatever steps required by law to help prevent potential harm from happening
3. Uses and disclosures for health and oversight activities
4. Uses and disclosures for judicial and administrative proceedings
5. If you report information indicating a child, disabled, or elderly person is suffering from abuse or neglect

You have the right to discuss with your counselor what information is in your record, and if you sign a release of information authorizing me to share information to share information with outside sources, you have a right to discuss what specific information will be released.

You are protected under HIPPA. This law insures the confidentiality of electronically transmitted information. If you choose to communicate with your therapist via email, please be aware that email is not a secure form of communication. Any email received from you, and any responses sent to you, will be placed in your treatment record.

Your Rights as a Patient Under HIPPA:

1. As a client you have the right to see your file, unless it would endanger your health or another person's health or safety.
2. As a client you may obtain a copy of your treatment, or a summary of your treatment.
3. As a client you have the right to request amendments to your counseling/therapy file.

4. As a client you have the right to receive a history of all disclosures of protected health information.
5. As a client you have the right to restrict the use and disclosure of your protected health information for the purpose of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
6. As a client you have the right to register a complaint with the Secretary of Health & Human Services if you feel your rights, herein explained, have been violated.

In addition to the above you have the right to ask questions about your treatment and the therapeutic process. You can ask your therapist to use different modalities or let them know if something in your session is not working to your benefit. You are free to terminate therapy at any time or request a different therapist at any time. You have the right to be treated with respect and dignity and receive appropriate care without discrimination towards age, race, gender, sexual orientation, social economic status, or religious background.

Acknowledgement of Review & Receiving of Documents

Prior to your treatment, you will receive an exact duplicate of these pages and the Professional Disclosure Statement and Consent of Treatment for your personal records. It will be necessary for you to sign a certificate indicating that you have received, read, and understood both documents. This certificate will be placed in your file. Please do not sign the certificate if you do not understand any part of the Notice of Privacy Practices & Client's Rights, the Professional Disclosure, or the Consent for Treatment.

I acknowledge that I have received the Professional Disclosure, Consent for Treatment, and Notice of Privacy Practices & Client's Rights. I further acknowledge that I seek and consent to treatment with my therapist. My signature below confirms that I understand and accept all the information contained in the Professional Disclosure, Consent for Treatment, Notice of Privacy Practices & Client's Rights.

Can I leave a message on your home phone or cell phone? Yes No

Can I email you about scheduling? Yes No

_____	_____	_____
Printed name of client	Signature of Client	Date