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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Commitment to maintaining your privacy.
I am committed to maintaining the privacy and confidentiality of your medical and mental health information. Therefore, I will only release information in accordance with state and federal laws and with the ethics of the psychological profession. This notice describes my policies regarding disclosure of your healthcare information.

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes. Unless otherwise noted, ***I will obtain your written consent prior to disclosing this information***. Please do not hesitate to ask if you have questions about any of this information.

> **TREATMENT** I may use your health information to treat you. For example, I may discuss relevant information with your physician or another health care provider. I may also discuss your information with the individual who gave you my name or with family members.
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> **PAYMENT** I may use and disclose your health information to bill and collect payment for the services you receive from me. I may disclose health information to obtain payment from third parties that may be responsible for the cost of treatment, such as family members. I may also use your health information to bill you directly for services.
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> **HEALTHCARE OPERATIONS** I may use and disclose health information in order to conduct a review of my treatment procedures, review my business activities, for purposes of certification, and to comply with federal and state regulations and licensing activities.
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> **USES AND DISCLOSURES WITHOUT YOUR CONSENT** Health information may be used as required by law, including mandated reporting. I may also use information to report emergencies, and criminal damage. I may contact you to schedule an appointment and to discuss treatment options and alternatives.

Method of disclosure.
Please note that I may maintain electronic records. I may submit healthcare information electronically. Information may be sent to my billing agency, Medical Billing Center of Colorado for the purposes of

obtaining payment. I do not recommend using email to send sensitive information. ***I cannot fully guarantee the privacy of personal identification information, financial information, or insurance information that is sent to me electronically.*** Electronic information of this nature will be deleted regularly from my email account. I do use a fax to communicate health information. Such information is marked confidential. I may also use text messaging to contact you regarding appointment scheduling. These messages will be deleted regularly from my phone. You have the right to request that information be submitted in a method other than fax, text or electronically. I may also send correspondence to you through US mail. You may request that such correspondence be sent to an alternative address or through another method.

CLIENT RIGHTS

In the Notice of Privacy Practices counselors are required to inform clients as to their rights under federal and state law.

***************PLEASE COMPLETE*************************

2. You have the right to request where I may contact you

Home? yes or no ____
message ok? yes or no

Work? yes or no____
message ok? yes or no

Cell phone? yes or no _____________________________________
Voice message ok? yes or no
Text message? yes or no

Email? yes or no ____

If not, how may I contact you________________________________

3. You have the right to release your medical records

I will obtain written authorization to release your records to others. You have the right to revoke a release in writing. Please note that the revocation is not valid to the extent that you have acted in reliance on such previous authorization.

4. You have the right to inspect and copy your medical billing records

You have the right to inspect and copy your records. I may deny this request if I feel viewing your records may be harmful to you. If you request a copy of your records that exceeds 15 pages, I may charge you $0.10 per copy and for postage.

5. Right to add information or amend your medical records

You may request to amend your records. If you are considering amending your records, you will have 14 days to decide to do so. I may deny the request to amend records. You may file your disagreement with my denial to amend records and your response will be filed in the record Any request to amend records must be in writing.

6. **You have a right to accounting of disclosures I have made** for a six-year period. This includes disclosure for treatment, payment or healthcare options disclosures pursuant to a signed release, and disclosure made to you and disclosures for national security or law enforcement purposes.

7. **You have the right to request restrictions on uses and disclosures of your healthcare information**

8. Such a request must be in writing and I am not obligated to agree with the request.

9. **You have the right to complain if you feel your privacy rights have been violated.**

   If you feel your privacy rights have been violated, please discuss your concerns with me. You may also complain to the Secretary of the Department of Health and Human Services, 200 Independence Ave., SW, Washington D.C., 20201. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

10. **You have a right to receive a written copy of any changes in my privacy policy**

    You may request any future changes and may also make a request to a privacy officer.

    Your signature below only acknowledges that you have received this Notice of Privacy Practices.

_____	_____	_____
Signature of client	Printed name	Date