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. Please review this notice carefully.

This Notice of Privacy Practices describes how we may use and disclose your Personal Health Information (PHI) (*see below for definition) in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA). It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI ad to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time.

Protected Health Information may not be used or disclosed in violation of Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45C.F.R. PARTS 160 AND 164) or in violation of state law.

My policy in regard to release of information is as follows: Unless otherwise permitted or required as articulated below, the release of any medical/ psychological/ social information to any person or agency requires your signed authorization. You have a right to revoke consent or authorization at any time.

I may use or disclose PHI without your consent or authorization in the following circumstances: Child abuse, adult and domestic abuse regarding an individual over the age of 60, serious threat of imminent harm against another or to yourself, health oversight activities, pursuant to a subpoena (with your consent), court order, administrative order or similar process. You may request a detailed definition of these items.

• I may release PHI for treatment provision, coordination, and management of health care and related services, payment, or health care operations.

• I have the right to release information to your insurance agency as required to satisfy their requirements/ inquiry regarding billing and/ or regarding precertification for treatment (if precertification is required).

• If it becomes necessary to use collection processes due to lack of payment for services, I will disclose only the minimum amount of PHI necessary for purposes of collection.

• In addition, I must make disclosures to the Secretary of the Department to Health and Human Services for the propose of investigating or determining my compliance with the requirements of the Privacy Rule.

You may request restrictions regarding such disclosures of information, but I am not required to abide by your request. You may request that information be amended.

You have the following rights if you wish to exercise them: A right to request restrictions regarding disclosures of PHI; A right to receive confidential communication; A right to inspect and copy PHI and billing records, either paper or electronically; A right to amend PHI; A right to receive an accounting of disclosures of PHI; a right to breach notification; and a right to receive copies of this notice.

If, for some reason, a situation occurs that is not covered in this document, the guidelines of the HIPAA Privacy Rule will be used.

Your records are held private, and I will not release any information of any kind to any entity, unless allowed to or required by law or the HIPAA Privacy Rule. When I disclose any information, I will disclose as minimal amount of information as possible for the purpose it is required/ requested.

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Ave, S.W. Washington DC 20201 or by calling (202)619-0257. I will not retaliate against you for filing a complaint.

**Protected Health Information (PHI) is defined as (with certain exceptions): individually identifiable health information regarding the patient—it may include: medications prescribed and monitoring; counseling sessions beginning and termination dates; the modalities and frequencies of treatment furnished; results of clinical tests; and any of the following items—diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.*

Your signature below indicates that you have received a copy of this information.

Signature of Client_____ Date_____