NOTICE OF PRIVACY PRACTICES

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Health Insurance Portability and Accountability Act (HIPAA). This notice is based on online HIPAA information, information from other professional organizations, and the Code of Virginia.

Effective April 14, 2003

I am a mental health care provider and more specifically, I am a Licensed Marriage and Family Therapist, licensed by the State of Virginia. I create and maintain treatment records that contain individually identifiable health information about you. These records are generally referred to as "medical records" or "mental health records," and this notice, among other things, concerns the privacy and confidentiality of those records and the information contained therein. 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 Release of Information Consent Form for any outside provider that you wish for me to exchange information with. Once you have signed the Consent Form, I may use or disclose your Protected Health Information for purposes of diagnosis, treatment, obtaining payment, or to conduct healthcare operations.

I may be required or permitted to disclose your personal health information (e.g., your mental health records) without your written authorization. The following circumstances are examples of when such disclosures may or will be made:

Abuse or Neglect: If I suspect abuse or neglect of a child or elder, I am mandated to make a report to the appropriate public 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.

PLEASE NOTE: The above list is not an exhaustive list, but informs you of most circumstances when disclosures without your written authorization may be made. Other uses and disclosures will generally (but not always) be made only with your written authorization. Uses or disclosures made with your written authorization will be limited in scope to the information specified in the

authorization form, which must identify the information "in a specific and meaningful fashion." You may revoke your written authorization at any time, provided that the revocation is in writing and except to the extent that I have taken action in reliance on your written authorization.

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. Usually this includes demographic and billing records but does not include psychotherapy notes. 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 copying, 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 the amendment must be in writing and must provide a reason supporting your request.

Right to an Accounting of Disclosures: You have the right to request an Accounting of Disclosures, a list of your information that has been disclosed to others that you have authorized. You must submit your request 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 Reception of Confidential Information: For example, you may request that I only contact you at a certain telephone number or address. You do not have to give a reason for your request.

Right to a Copy of this Notice: Other uses and Disclosures of Protected Health Information and any Psychotherapy Notes may 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 requirements.
If you believe your privacy rights have been violated, please let me know either in writing or by talking with me. Such a complaint will not result in any retaliation by me. You may also file a complaint with the Secretary of the US Department of Health and Human Services.

_____ _____

Signature of Client/Custodial Parent/Guardian Date

_____ _____

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