Debora J. Hayden, MSW

Licensed Clinical Social Worker

**PRIVACY & CONFIDENTIALITY STATEMENT**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Possible Use and Disclosure of your Medical Information** -Your health record contains symptoms, test results, diagnosis, treatment and a plan for future care, which is referred to as Protected Health Information (“PHI”). PHI may be used or disclosed for the purpose of:

* Providing, coordinating, or managing your health care treatment.
* Receiving payment for services (for collection processes only the minumum amount of PHI will be disclosed).
* Supporting business activities (such as calling to reschedule appointments or discuss payments).
* Legal requirement (for the Dept of Health & Human Services to determine compliance with the Privacy Rule.)

**Disclosure of Information Without Authorization**-Applicable law and ethical standards require disclosure of your information without your authorization or consent only in a limited number of other situations including:

* When mandated by state or federal law to report cases of known or suspected abuse or neglect of a minor, an elder, or a developmentally disabled individual.
* When necessary to prevent or lessen a serious and imminent threat of physical harm to self or others (including suicidal or homicidal thoughts). Information will be disclosed to a person reasonably able to prevent or lessen the threat, including the target of the threat.
* When specifically ordered by a court of law. This may include information that was obtained during couple/marital/family therapy joint sessions. Whatever precautions that can be taken will be taken to protect the individuals, though disclousure may involve all members and may be required even if one individual objects.

**Your Rights Regarding your PHI**

* **Right of Access to Inspect and Copy**: You have the right to inspect and copy PHI that may be used to make decisions about your care. Your right will be restricted only in those situations where there is compelling evident that access would cause serious harm to you. There may be a reasonable charge for copies.
* **Right to Amend**: If you feel that your PHI is incorrect or incomplete you may ask for an amendment to the information, though the request may not be upheld.
* **Right to an Accounting of Disclosures**: You have the right to request an accounting of your PHI disclosures for five years prior to the date you ask. There may be a reasonable fee charged if you request more than one accounting in any 12-month period.
* **Request Confidential Communications**: You have the right to request you be contacted in a specific way, (e.g. home, cell or office phone) or to send mail to a different address. All reasonable requests shall be honored.
* **Right to Request Restrictions**: You may request certain health information for treatment or payment not be shared, though the request may be denied. Denying the request will not affect your care. If you pay for a service out-of-pocket in full you may request that information not be shared with your health insurer. This request will be granted unless a law requires the information be shared.
* **Right to Choose someone to Act for you**: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
* **Right to a Copay of this Notice**: You may request a copy of this notice at any time, either electronically or paper.
* **Right to File a Complaint**: You may file a complaint if you feel your rights have been violated. You may either file a complaint in writing to Debora J. Hayden, MSW, LCSW, Privacy Officer, or with the U. S. Dept of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr.privacy/hipaa/complaints](http://www.hhs.gov/ocr.privacy/hipaa/complaints). There will be no retaliatin against you for filing a complaint.

I understand I can revoke my consent at any time except to the extent that information has already been released. If I do not revoke my consent, it will expire automatically one year after services have ended or all claims for treatment have been paid. I hereby acknowledge I have read and understand the practices noted above.

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 *Signature of Client Or Parent/Guardian Signature of Licensed Clinical Social Worker Date*