Notice of Privacy Policies

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the provided Authorization to Release Information form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing at any time, by contacting me.

Il. Limits of Confidentiality

There are some important exceptions to this rule of confidentiality — some exceptions created voluntarily by my own choice and some required by law. If you wish to receive mental health services from me, you must sign this form indicating you understand and accept my policies about confidentiality and its limits.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter immediately to Child Protection and Permanency.

- Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by law to immediately make a report and provide relevant information to the Adult Protective Services.

- Serious Threat to Health or Safety: Under law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

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Ill. Patient's Rights and Provider's Duties:

- Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

- Right to a copy of this notice: You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

- Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. A new copy will be given to you.

- Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

By signing below, I acknowledge that I have read these policies and consent to accept them as a condition of receiving mental health services.

Name of Patient	Name of Guardian, if under age 18
Signature of Patient or Guardian	Date