**NOTICE OF PRIVACY PRACTICES**

January, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. YOU HAVE THE RIGHT TO REQUEST A COPY OF THIS DOCUMENT AT ANY TIME. PLEASE READ IT CAREFULLY.**

You have the right to inspect and/or copy you medical record and request corrections or removal of incorrect information, but the following conditions must be met:









You must make an appointment to do so

The doctor has the right to remove information from your record before you see it if he/she thinks that seeing it would be harmful to your mental health. The reason for removing information from your record must be put in writing in your record.

You will be a provided a private place and staff member for assistance when reviewing your records.

You have a right to an explanation of your condition and treatment.

You must pay in advance a fee determined by the amount of copies or the time spent by personnel on your review of your records.

You have a right to have you clinical information kept confidential with the restraints of the law.

You will be required to sign (in some cases) several requests for release of information in order for us to send a copy of your treatment information to the following: (You have a right to refuse the following, but will be required to pay for your visit, in full, at the time of service):









If your case is a legal case: a copy of your case note is sent to your attorney or insurance company for each visit.

If your insurance company requires a treatment plan for authorization of visits to obtain payment of your visit.

To check on non-payment by your insurance company.

If you or your insurance company requires that a treatment plan or progress notes be sent or faxed to your primary care physician.

If you request that a copy of your progress notes or a letter of treatment is sent to another provider or insurance company or attorney.

If you authorize your insurance company to pay us for visits. If you are part of an EAP program through your work and communication with your Employee Assistant Counselor is required.

**IN SOME OF THE ABOVE CASES, WE WILL BE FAXING INFORMATION IN ORDER TO SAVE TIME AND COST.**

Your medical information will be released without your written consent in the following situations: If you are in need of emergency care. If information is needed for hospital care.

 

    





If you are a danger to yourself or someone else and the doctor must provide information to authorities such as police, ambulance, hospital, or crisis unit.

To verify insurance coverage prior to your visit. In reported cases of child abuse or child neglect.

Printed name: Date:

 

Signature: