Flow | THERAPEUTIC ASSOCIATES

PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request. All information revealed by you in a counseling session and most information placed in your file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA. As such, your protected health information ***cannot be distributed to anyone else without your express informed and voluntary written consent or authorization.*** The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in the disclosure statement.

Use or disclosure of the following protected health information <u>does not require</u> your consent of authorization:

1. Uses and disclosures required by law-*like files court-ordered by a Judge*
2. Uses and disclosures about victims of abuse, neglect, or domestic violence-*like the duties to warn explained in the Disclosure Statement*
3. Uses and disclosures for health and oversight activities-*like correcting records or correcting records already disclosed*
4. Uses and disclosures for judicial and administrative proceedings-*like a case where you are claiming malpractice or breech of ethics*
5. Uses and disclosures of law enforcement purposes-*like if you intend to harm someone else*
6. Uses and disclosures to avert a serious threat to health or safety-*like calling Probate Court for a commitment hearing*
7. Uses and disclosures for Worker's Compensation-*like the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim*

Your Rights as a Patient under HIPAA:

1. As a client, you have the right to see your file, unless it would endanger your health or another person's health or safety. *Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are excluded from this right*
2. As a client you may obtain a copy of your treatment, or a summary of your treatment. There is a standard administrative fee for copies a fee for a treatment summary may apply.
3. As a client you have the right to request amendments to your counseling/therapy file
4. As a client you have the right to receive a history of all disclosures of protected health information. You will be required to pay any copying fees @ $.20 a page.
5. As a client you have the right to restrict the use and disclosure of your protected health information for the purpose of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.

6. As a client you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Prior to your treatment, you will receive 1.) an exact duplicate of these pages and the Professional Disclosure Statement and Consent of Treatment-both for your personal records. It will be necessary for you to sign a certificate indicating that you have received, read and understood both documents. This certificate will be placed in your file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights of the Professional Disclosure Statement and Consent for Treatment. Your counselor will be happy to explain these documents further.

I acknowledge that I have received and read the ***Professional Disclosure Statement and Consent for Treatment*** and the ***HIPAA Client's Rights.*** I further acknowledge that I seek and consent to treatment with my therapist. My signature below confirms that I understand and accept all the information contained in the ***Professional Disclosure Statement and Consent for Treatment*** and the ***HIPAA Client's Rights.***

Can we leave a message on your home phone or cell phone? **Yes** **No**

Printed name of Client | Signature of Client | Date

If more than one individual (e.g., spouse or family member) is seeking counseling, please have each of the others sign below. Signatures below confirm that each understands and accepts all the information contained in the ***Professional Disclosure Statement and Consent for Treatment*** and the ***HIPAA Client's Rights,*** and that each seeks and consents to treatment. We will provide additional copies of the ***Professional Disclosure Statement and Consent for Treatment*** and the ***HIPAA Client's Rights*** upon request.

Signature of Client # 2 | Signature of Client # 3