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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed. It also outlines how you may obtain access to this information.

Please review this document carefully. The privacy of your health information is important to me.

MY LEGAL DUTY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this notice about my privacy practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this notice while in effect. This notice takes effect on April 14th 2003, and will remain in effect until I replace it.

I reserve the right to change privacy practices and the terms of this Notice at any time, providing that applicable law permits the changes. I reserve the right to make changes in my privacy practices and the new terms of my notice effective for all health information that I maintain. This is to include health information that I created or received before I made changes to my privacy practices. I will make the new changes in the notice available upon request.

You may request a copy of this notice at any time. For more information about my privacy practices, or for additional copies of this notice, please contact me using the information listed at the beginning of this notice.

USE AND DISCLOSURE OF HEALTH INFORMATION

I use and disclose health information about you for healthcare operation, treatment and payment. For example:

1. **Treatment**: I may use or disclose your health information to another physician or healthcare provider for your treatment.

2. **Payment**: I may use or disclose your health information to obtain payment or authorization for services I provide to you.

3. **Healthcare Operations**: I may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professional, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

4. **Your Authorization**: In addition to our uses of your health information for treatment, payment authorization or healthcare operations, you may give me written authorization to use your health information or to disclose to anyone for any purpose. If you give me an authorization, you may evoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give me written authorization, I cannot use or disclose your health information for any reason except those described in this notice.

5. **To Your Family and Friends**: I must disclose your health information to you, as described in the Patient Rights section of this notice. I may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that I may do so.

6. **Persons Involved in Care**: I may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior use or disclosure of your health information, I may provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination, using professional judgement relevant to the person's involvement in your healthcare. I will also use my professional judgment and my experience with common practice to make reasonable inferences to your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or similar forms of health information.

7. **Marketing Health-Related Services**: I will not use your health information for marketing communications without your written authorization.

8. **Required by Law**: I may use or disclose your health information, to the appropriate agency, when I am required to do so by law.

9. **Abuse and Neglect**: I may use or disclose your health information to the appropriate authorities if I reasonably believe that you are a possible victim and/or perpetrator of abuse, neglect, domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health and safety or the health and safety of others.

10. **National Security**: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose health information to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institutions or law

enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

11. **Appointment Reminders**: I may use or disclose your health information to provide you with appointment reminders and/or billing statements (such as voicemail messages, postcards or letters).

PATIENTS' RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the beginning of this notice. I may charge you a reasonable fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which I or my business associates disclose your health information for purposes, other than treatment, payment, authorization or health operations and certain activities, for the past six years. This will only be available after April 14th 2003. If you request this accounting more than once in a 12 month period, I may charge you a reasonable fee for responding to these additional requests.

Restriction: You have the right to request that I place additional restrictions on our use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that I communicate with you about your health information by alternative means or at alternative locations. You must make a request in writing. You request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location request.

Amendment: You have the right to request that I amend your health information. Your request must be made in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about my privacy practices or you have questions/concerns, please discuss this with me.

If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about access to your health information, or in response to a request you made to amend or restrict the use of disclosure of your health information, or to have me communicate with you by alternative means or at an alternative location, you may contact me at the information listed at the beginning of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services and/or to the California Board of Behavioral Sciences.

I support your right to the privacy of your health information. I will not retaliate in any way if you choose to file a complaint with me or the U.S. Department of Health and Human Services and/or to the California Board of Behavioral Sciences.

Please sign below to acknowledge that you have read and understood the above information and agree to pursue psychotherapy in accordance with the Health Insurance Portability and Accountability Act.

Name:_____

Signature:_____

Date:_____ /_____ /_____