HIPAA Notice of Privacy Practices and Patient's Rights

Client Name _____ **DOB** _____

This notice provides you with information about the rights you have as a client of Oaks Family Counseling, how your mental health records may be used, and our legal duties as treatment providers. We are required to provide you with this notice under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. This law is designed to protect the confidentiality of your treatment and medical records. Your medical records are used to provide treatment, bill and receive payments, and conduct our healthcare operations. You are asked to sign this agreement to receive services. If you do not agree to the information provided in this notice, we cannot treat you.

This notice describes how medical information about you may be used and/or disclosed and how you can gain access to it. Please review carefully. Please let us know if you have any questions or would like additional information.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Use and disclosure of medical records is limited to internal use except as required by law or authorized by the patient or legal representative.

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure puts you at risk of harm.

3. Disclosed information will be limited to the minimum necessary.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures; however, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative in writing except when disclosure is required by law or in an emergency.

9. If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns/questions about your privacy rights, you may speak with your counselor privately about any of your concerns.

10. If you believe that your privacy rights have been violated and wish to file a complaint, you may request a Client Compliant Form from your counselor. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You have specific rights under the Privacy Rule. Oaks Family Counseling will not retaliate against you for exercising your right to file a complaint.

11. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION. THIS ACKNOWLEDGEMENT WILL BECOME PART OF YOUR RECORDS.

Signature of Client _____ Date _____

Signature of Parent/Guardian (if minor) _____ Date _____