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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 therapy session and most information placed in your therapy 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 (PHI) 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 and Consent for Treatment.

Use or disclosure of the following protected health information does not require your consent or 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 for law enforcement purposes (like if you intend to harm someone else - see Duties to Warn in Disclosure statement)
6. Uses and disclosures for research purposes (like using client information in research; always maintaining client confidentiality)
7. Uses and disclosures to avert a serious threat to health or safety (like calling Probate Court for a commitment hearing)
8. 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 Counseling/Therapy Client under HIPAA

* As a client, you have the right to see your therapy file. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right
* As a client, you have the right to receive a copy of your therapy file. This file copy will consist of only documents generated by me. You will be charged copying fees @ $.20 a page. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right
* As a client, you have the right to request amendments to your file.
* As a client, you have the right to receive a history of all disclosures of PHI. You will be charged copying fees @ $0.20 a page.
* As a client, you have the right to restrict the use and disclosure of PHI for the purposes of treatment, payment, and operations. If you choose to release any PHI, you will be required to sign a Release of Information form detailing exactly to whom and what information
* 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 therapy, you will receive 1.) An exact duplicate of this page and 2.) The Professional Disclosure Statement and Consent for Treatment - both for your personal records. It will be necessary for you to sign this certificate indicating that you have received, read, and understand both documents. This certificate will be placed in

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your therapy file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights or the Professional Disclosure Statement and Consent for Treatment. I will be happy to explain these documents further.

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

_____

Signature of Client Date

_____

Signature of Parent or Guardian (if under age 18) Date