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## **Notice of Privacy Practices**

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I will only release information in accordance with state and federal laws and the ethics of the counseling profession. I am required to provide you with this notice that describes my policies related to the use and disclosure of your healthcare information.

### **Permitted Uses and Disclosures**

Providing treatment services, collecting payments and conducting healthcare operations are necessary activities for quality care. Upon your signing of this notice, state and federal laws allow me to use or disclose your protected health information for the purposes described in the following examples:

#### **Treatment**

I may consult with other personnel involved in your health care to determine the best treatment for you.

#### **Payment**

I may use or disclose information in your health record to obtain reimbursement from you for services rendered to you.

#### **Health Care Operations**

Your health records may be used to help me review treatment procedures and to comply with supervision and licensure requirements.

### **Uses and Disclosures Requiring Authorization**

I may use or disclose your health information for purposes outside of treatment, payment and health care options. This will require permission from you in the form of a signed authorization. You may revoke all such authorizations at any time, provided each revocation is in writing.

### **Uses and Disclosures Without Your Consent**

There are certain circumstances under which I may use or disclose your health information without your consent. Those circumstances generally involve:

#### **Child Abuse, or Vulnerable Adult Abuse**

If I have reasonable cause to believe abuse or neglect has occurred I am mandated to report it.

#### **Serious Threats to Health or Safety**

I may disclose health information to prevent threats to you or any other person.

#### **Judicial and Administrative Proceedings**

I may disclose health information about you in response to a court order.

### **Health Oversight Activities**

I may disclose information for disciplinary proceedings, investigations, and supervision.

### **Client Rights**

You have the following rights regarding health information I maintain about you:

#### **Right to Request Confidential Communications**

You have the right to request and receive confidential communications of your health information by alternative means.

#### **Right to Release Your Medical Records**

You have the right to request restrictions on certain uses and disclosures of your health information. However, I am not required to agree to a restriction you request.

#### **Right to Inspect and Copy**

You have the right to inspect and copy your health information used to make decisions about your care. I may deny your access under certain circumstances, and in some cases you may have this decision reviewed.

#### **Right to Request an Amendment**

You have the right to request an amendment to your health information. I may deny your request.

#### **Right to Accounting of Disclosures**

You have the right to receive a list of disclosures made by me of your health information.

#### **Right to Request Restrictions**

You have the right to request a restriction or limitation on the health information I use or disclose about you. I am not required to agree to your request.

#### **Right to a Paper Copy**

You have the right to a paper copy of this notice whether or not you have previously agreed to receive the notice electronically.

#### **Right to Complain**

If you believe that your privacy rights have been violated, bring it to my attention or to the attention of Colleen Biri, Psy.D at 314-330-4318. You also have the right to send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing such a complaint.

#### **Right to Receive Changes in Policy**

I reserve the right to change the terms of this privacy notice at any time, making the new provisions effective for health information I already have about you as well as any information I receive in the future. In the event I revise this notice, I will provide you with a revised notice at your next visit. A change to any term of this notice may not be implemented prior to the effective date of the notice in which such material change is disclosed to you.

I hereby acknowledge that I have received a copy of this Notice of Privacy Practices and consent to the use of my protected health information as permitted or required by law.

Name: \_\_\_\_\_  
Signature of Parent or Legal Guardian of Minor Child

Date: \_\_\_\_\_