ENJOY LIFE MORE

C0UNSELING AND COMMUNICATION SERVICES

PENNIE J. MCKAY, MA, LCPC, LMFT, NCC
Licensed Clinical Professional Counselor
Licensed Marriage and Family Therapist

NOTICE OF PRIVACY PRACTICES

(HIPPA related)

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

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

My Legal Duty:

In addition to the licensing standards of my profession, I am required by applicable federal and state laws to maintain the privacy of your health information. I reserve the right to change my privacy practices and the terms of this notice at any time, and will make these changes available to you.

USES AND DISCLOSURE OF HEALTH INFORMATION

I use and disclose health information about you for treatment and payment subject to the following:

PAYMENT: I may use and disclose your health information in order to obtain payment for services I provide to you.

TREATMENT: I may use or disclose your health information to a physician or other healthcare provider providing treatment to you only when you authorize me to do so by a signed Release of Information.

YOUR AUTHORIZATION:
Additionally, you may give me written authorization to disclose your health information to anyone for any purpose. If you give me an authorization, you may revoke it at any time.

AS REQUIRED BY LAW:
I may use or disclose your health information when I required to do so by law. If I receive a subpoena from an authority of the court, you indicate you intend to end your life or that of someone else, or you report that anyone under 18 years of age has been abused or neglected.

TO YOUR FAMILY AND FRIENDS: I must disclose your health information to you as described in the Client's 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 health care, but only if you agree in writing that I may do so.

ABUSE OR NEGLECT: I may disclose your health information to appropriate authorities if I reasonably believe you are a possible victim of abuse, neglect or 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 or safety or the health or safety of others.

APPOINTMENT REMINDERS: I may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters).

CLIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that I provide information in a format other than photocopies. I will use the format you request unless I cannot practically do so. You must make a request in writing to obtain access to your health information. I will charge you a reasonable cost-based fee for expenses such as copies and time.

RESTRECTION: You have a right to request that I place additional restrictions on my 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.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which I disclosed your health information for purposes other than treatment or payment and certain other activities prior to April 14, 2003. If you request this accounting more than once in 12 month period, I may charge you a reasonable, cost based fee for responding to these additional requests.

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

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

You may contact me directly regarding any questions or complaints that you have about my privacy policies. If you are concerned that I may have violated your privacy rights, or you disagree with a decision that I made about access to your health information, you may complain directly to this office. You also may submit a written complaint to the U.S. Dept. of Health and Human Services. I will not retaliate in any way if you choose to file such a complaint. Your right to the privacy of your health information is of paramount importance to me.

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Clients please complete below:

My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Notice of Privacy Practices.

____ __________________
Client's Signature Date

____ __________________
Parent/Guardian's Signature Date

____ __________________
Parent/Guardian's Signature Date

____ __________________
Witness' Signature Date

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