NOTICE OF PRIVACY RIGHTS

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FOR YOUR PROTECTION 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.

YOUR HEALTH INFORMATION IS PRIVATE.
I understand that the information I record about you and your health is personal. Keeping your health information private is one of my most important responsibilities. I am committed to protecting your health information and following all laws regarding the use of your health information. The law says:

1. I must keep your health care information from others who do not need to know it.
2. You may ask that I not share certain healthcare information. (In some instances, I may not be able to agree with your request.)

A. USES AND DISCLOSURES OF PROTECTED INFORMATION
   1. *Payment*. Payment refers to the activities undertaken by a mental health provider [including mental health provider] to obtain or provide reimbursement for the provision of health care. With your consent, I will provide information to your insurance company for services provided. The information provided to insurers and other third-party payors may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.
   2. *Required by Law*. I will disclose protected health information when required by law. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when a client is a danger to self or others or gravely disabled; and (e) when a Coroner is investigating a client's death.
   3. *Family members*. Except for minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.
   4. *Emergencies*. In life-threatening emergencies, I will disclose information necessary to avoid serious harm or death.
   5. *Client authorization or release of information.* I may not use or disclose protected health information in any other way without a signed authorization or release of information. You may be asked to sign a form, called an authorization form, allowing your health care information to go somewhere else if:
      a. You want us to send it to another health care provider; or,
      b. You want it sent to another person for you.

      The authorization form tells us what, where and to whom the information must be sent. Your authorization is good for six (6) months or until the date you put on the form. NOTE: If you are less than 18 years old, your parents or guardians will receive your private health information, unless by law you are able to consent for your own health care treatment. If you are, then your private health information will not be shared with parents or guardians

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unless you sign an authorization form. You may also ask to have your health information sent to a different person that is helping you with your health care.

6. *Revocation of release of information.* When you sign an authorization or a release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent that I had already taken action in reliance thereon.

B. YOUR RIGHTS AS A CLIENT

1. *Access to protected health information.* You may see your health information, however, I retain the right to withhold private therapy notes if I feel that this is detrimental to you or if it is part of a legal case. Most of the time you can receive a copy if you ask. You may be charged a small amount for the copying costs.
2. *Amendment of your record.* If you think some of the information in your record is wrong, you may ask in writing that it be changed or new information be added. You may ask that the changes or new information be sent to others who have received your health information from us.
3. *Accounting of Disclosures.* You have the right to receive an accounting of certain disclosures I have made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of payment. In addition, does not include disclosures made to you or disclosures made pursuant to a signed disclosure.
4. *Copy of this notice.* This notice is yours. You have a right to obtain another copy of this notice upon request.

C. QUESTIONS OR COMPLAINTS?

If you have any questions about this notice, or you think that I have not protected your private health information and you wish to complain about it, please contact either of the following:

Colorado State Department of Regulatory Agencies 1560 Broadway, Suite #1340 Denver, CO, 80202 (303) 894-7766	Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201-0004 (800) 368-1019

It is against the law for me to take any retaliatory or other negative action against you if you file a complaint. I have received a copy of my notice of privacy rights.

_____ _____
Client Name(s) (please print) Date

_____ _____
Client Signature (parent or guardian if a minor) Date

_____ _____
Client Signature (parent or guardian if a minor) Date