Cherie Baetz-Davis, Ph.D., LLC
Compassionate Psychological Care

PRIVACY & CONFIDENTIALITY STATEMENT

Client Name: ______________________________ DOB: ______________ SSN: __________________

Possible Use and Disclosure of Your Medical Information - Your health record contains symptoms, test results, diagnosis, treatment and a plan for future care - Protected Health Information ("PHI"). PHI may be used or disclosed for the purpose of:

- providing, coordinating, or managing your health care **treatment**
- receiving **payment** for services (for collection processes only the minimum amount of PHI will be disclosed)
- supporting **business activities** (i.e. scheduling appointments, or billing through an agency with a HIPPA contract.)
- **legal requirement** (for the Dept of Health & Human Services to determine compliance with the Privacy Rule or in response to a court order or subpoena.)

Disclosure of Information Without Authorization - Applicable law and ethical standards require disclosure of your information without your authorization or consent only in a limited number of other situations including:

1) When mandated by state or federal law to report cases of known or suspected **abuse or neglect** of a minor, an elder, or a developmentally disabled individual.
2) When necessary to prevent or lessen a serious and **imminent threat of physical harm to self or others** (including suicidal or homicidal thoughts). Information will be disclosed to a person reasonably able to prevent or lessen the threat, including the target of the threat.
3) When specifically **ordered by a court of law**. This may include information that was obtained during couple/marital/family therapy joint sessions. Whatever precautions that can be taken will be taken to protect the individuals, though disclosure may involve all members and may be required even if one individual objects.

Your Rights Regarding Your PHI

- **Right of Access to Inspect and Copy.** You have the right to inspect and copy PHI that may be used to make decisions about your care. Your right will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. There may be a reasonable charge for copies.
- **Right to Amend.** If you feel that your PHI is incorrect or incomplete, you may ask for an amendment to the information, though the request may not be upheld. If not, you will receive a written explanation within 60 days of your request.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of your PHI disclosures for 6 years prior to your request. A reasonable fee may be charged if more than one accounting is requested in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a limitation on the disclosure of your PHI without your care being affected, though the request may not be upheld. If you self-pay you do not have to share PHI with your insurer.
- **Right to Request Confidential Communication.** You have the right to request you be contacted in a specific way (i.e. home, cell, office phone) or to send mail to a different address.
- **Right to Choose Someone to Act for You.** If you have given someone medical power of attorney or have a legal guardian, that person can exercise your rights and make choices about your health information.
- **Right to Share PHI.** You have the right to request your PHI shared with family, close friends, or others involved in your care if a Release of Information Form has been signed.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.
- **Right to File a Complaint.** If you believe your rights have been violated, you have the right to file a complaint in writing to Cherie Baetz-Davis, Ph.D., Privacy Officer, or with the Secretary of Health & Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 or at (877) 696-6775 or www.hhs.gov/ocr.privacy/hipaa/complaints/. There will be *no retaliation* against you for filing a complaint.

I understand I can revoke my consent at any time except to the extent that information has already been released. If I do not revoke my consent, it will *expire automatically one year* after services have ended or all claims for treatment have been paid. I hereby acknowledge I have read and understand the practices noted above.

______________________________	______________________________	______________
Signature of Client OR Parent/Guardian	*Signature of Psychologist*	*Date*

☐ Copy given to the client/parent/guardian ☐ Copy placed in chart by client's choice

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