

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14th, 2003.

My Legal Duty

I understand that your health/mental health information is personal and I am committed to protecting this information. I am required by applicable federal and state law to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also requires that I give you this Notice about my legal duties, my privacy practices, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect.

Individually identifiable information about your past, present, or future health/mental health or condition, the provision of health/mental health care to you, or payment for the health/mental health care is considered "Protected Health Information (PHI)." Whenever possible, the PHI contained in your record remains private. In some circumstances, it is necessary for me to share some of the PHI contained in your record (or your child's record). In all but certain specified circumstances, I will share only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

I reserve the right to change this notice and to make changes in my privacy practices. Any changes will be effective for all PHI that I maintain, including health/mental health information created or received before I made the changes. I will post a copy of the current notice in my reception area and on my website (if applicable). You may also request a current copy of this notice from me. For more information about my privacy practices, please contact me at number listed at the end of this notice.

How I May Use and Disclose Health/Mental Health Information About You:

The following categories describe different ways that I use and disclose your PHI. For each category, I explain what I mean, and offer an example. In some instances a written authorization signed by you is required in order for me to use or disclose your PHI; in others it is not. I have tried to identify which instances do not require your signed authorization and which do.

Uses and Disclosures of PHI For Which No Signed Authorization is Required:

For Treatment: I may use/disclose your PHI (or your child) to provide you with mental health treatment or services. For example, I can disclose your PHI to physicians, psychiatrists, and other licensed health care providers who provide you with health care services or are involved in your care. If a psychiatrist is treating you, I can disclose your PHI to your psychiatrist in order to coordinate your care.

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For Payment: I may use/disclose your (or your child's) PHI in order to bill and collect payment (from you, your insurance company, or another third party) for services provided by me. For example, I may send your PHI to your insurance company to get paid for the services we provided to you or to determine eligibility for coverage.

For Health Care Operations: I may use/disclose your (or your child's) PHI to your health care service plan or insurance company for purposes of administering the plan, such as case management and care coordination.

Appointment Reminders or Changes in Appointments: I may use/disclose your (or your child's) PHI to contact you as a reminder that you have an appointment. I may also contact you to notify you of a change in your appointment. For example, if I am ill, I may have someone in my office contact you to notifying you that the appointment is cancelled. *If you do not wish me to contact you for appointment reminders or changes in appointment times, please provide me with alternative instructions (in writing).*

When Disclosure is Required by state, federal or local law; judicial or administrative proceedings; or law enforcement: I may use/disclose your (or your child's) PHI when a law requires that I report information about suspected child, elder or dependent adult abuse or neglect; or in response to a court order. I must also disclose information to authorities that monitor compliance with these privacy requirements.

To Avoid Harm: I may use or disclose limited PHI about you when necessary to prevent or lessen a serious threat to your health or safety, or the health and safety of the public or another person. If I reasonably believe you pose a serious threat of harm to yourself, I may contact family members or others who can help protect you. If you communicate a serious threat of bodily harm to another, I will be required to notify law enforcement and the potential victim.

Law Enforcement Officials: I may disclose your (or your child's) PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or grand jury or administrative subpoena.

For Health Oversight Activities: I may disclose PHI to a health oversight agency for activities authorized by law. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

Specialized Government Functions: I may disclose you (or your child's) PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

Disclosure to Relatives, Close Friends and Other Caregivers: I may use or disclose your PHI to a family member, other relative, a close personal friend or any other person that you indicate is involved in your care or the payment of your care unless you object in whole or in part. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, I may exercise my professional judgment to determine whether a disclosure is in your best interests. If I disclose PHI to a family member, other relative or a close personal friend, I would disclose only information that I believe is directly relevant to the person's involvement with your health care or payment related to your health care.

Workers' Compensation: I may disclose your PHI as authorized by and to the extent necessary to comply with California law relating to workers' compensation or other similar programs.

As required by law: I may use and disclose your (or your child's) PHI when required to do so by any other law not already referred to in the preceding categories.

Uses and Disclosures of PHI For Which a Signed Authorization is Required: For uses and disclosures of PHI beyond the areas noted above, I must obtain your written authorization. Authorizations can be revoked at any time in writing to stop future uses/disclosures (except to the extent that I have already acted upon your authorization).

Your Rights Regarding Your (or Your Child's) PHI:

You have the following rights regarding PHI I maintain about you (or your child):

Right to Inspect and Copy: You have the right to inspect and copy your (or your child's) health/mental health information upon your written request. However, some mental health information may not be accessed for treatment reasons and for other reasons pertaining to California or federal law. I will respond to your written request to inspect records. A charge for copying, mailing and related expenses will apply.

Right to Request Restrictions: You have the right to ask that I limit how I use or disclose your PHI. I will consider your request, but I am not legally required to agree to the request. If I do agree to your request, I will put it into writing and comply with it except in emergency situations. I cannot agree to limit uses and/or disclosures that are required by law.

Right to Amend: If you believe that there is a mistake or missing information in my record of your health/mental health information, you may request, in writing, that I correct or add to the record. I will respond to your request within 60 days of receiving it. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request to amend information that: was not created by me, not part of my records, not part of the information that you would be permitted to inspect and copy or is accurate and complete.

Right to an Accounting of Disclosures: You have a right to get a list of when, to whom, for what purpose, and what content of your (your child's) PHI has been disclosed. This applies to disclosures other than those made for purposes of treatment payment, or health care operations. Your request must be in writing and state a time period (which may not be longer than six [6] years and may not include dates before April 14, 2003). I will respond to your request within sixty (60) days of receiving it. The first list you request within a 12 month period will be free. There may be a charge for more frequent lists. In such a case, I will notify you of the cost involved and you may choose to change or withdraw your request before any costs are incurred.

Right to Request Confidential Communications: You have the right to request that I communicate with you about health/mental health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must make your request in writing. Please specify how or where you wish to be contacted. I will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have a right to a paper copy of this notice. You may ask me to give you a copy

of this notice at any time.

Complaints:

If you think that your privacy rights have been violated you may contact me at 2416-A Central Ave, Alameda, CA 94501, or you may file a complaint the Secretary of the United States Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.

AUTHORIZATION FOR USE/DISCLOSURE OF CONFIDENTIAL INFORMATION (HIPAA and California Law)

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information. All information requested must be provided for this Authorization to be valid.

Use and disclosure of Mental Health Information:

Client Name: _____ Date of Birth: _____

My therapist, _____ **is authorized to (check all that apply):**

- Release or disclose records and/or information to
- Obtain or use records and/or information from
- Mutually discuss and exchange records and/or information

This Information should only be released to: (Provide name or function of person(s) or organizations to whom the information is to be released).

(Name of Person or Organization)

Specific Information to be Released/Obtained (Please select only one):

- All health/mental health information including diagnosis and treatment received.
- Only the following records or type of information:

Please specify if any information is to be excluded.

This disclosure of information authorized by Client is required for the following purpose:

This authorization shall become effective immediately and expire in one year. A photocopy or facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Your Rights:

- You may refuse to sign this Authorization.
- You may revoke this Authorization only by delivering your revocation in writing to _____ (therapist). Your revocation will be effective when your therapist receives it. However, this revocation will not

extend to information that was already obtained or released (used or disclosed) prior to the revocation.

- You have the right to receive a copy of this Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

Signature of Client/Parent/Guardian

Date

Your Relationship to the Client:

To Revoke Authorization Only:

Authorization Revoked: ___/___/___

Signature of Client/Parent/Guardian