Office of David L. Johns, LMHC

[redacted]

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, you have specific privacy rights as a client of mental health services. The purpose of this form is to notify you of these rights.

Under HIPAA, you have the right to:

1. Inspect your own health information and obtain a copy (excluding psychotherapy notes).
2. Request an amendment to health information (excluding psychotherapy notes).
3. Receive an accounting of disclosures for purposes other than treatment, payment, and healthcare operations.
4. Request that uses and disclosures of health information be restricted.
5. File a privacy complaint with me and/or the Secretary of HHS (Department of Health and Human Services). To file a complaint with me, you must do it in writing and you may either give it to me at your next appointment, or send it by mail to the above address. To file a complaint with the Secretary of HHS, you may go to the internet address: http://cms.hhs.gov/hipaa/hipaa2/default.asp or you may mail your complaint in writing to HIPAA Complaint, 7500 Security Blvd., C5-24-04, Baltimore, MD 21244. I will supply you with the needed form for mailing in a complaint. The information needed to file a complaint is your name, address, phone number, the name of the provider you are filing the complaint about, the provider's Tax Identification Number, and the provider's address and telephone number.

As your provider, I have a legal responsibility under Federal Law and HIPAA to protect your health information and to release only the minimum necessary information for the purposes of treatment, payment or healthcare operations, unless otherwise specifically authorized by you.

Everything you discuss with me will be kept in the strictest confidence, except for matters pertaining to 1) plans to harm yourself or someone else, 2) the abuse or neglect of minors, the elderly, or persons with disabilities, 3) illegal activity resulting in a court order, 4) information required for payment, and 5) anything else required by law. For any of these matters, I would legally and ethically be required to break confidentiality and involve others. Of course, I am also willing to share information with any other professional or agency you wish me to, as long as you sign an authorization form permitting me to release specific information to the named person or agency.

I,_____ fully understand what I have read and that I will receive a copy of this "Notice of Privacy Rights and Practices". I also understand that if there are any changes to this form I will be notified in writing and given a new form to sign, as well as a copy.

_____ _____ _____

Client Name & Signature Date:

_____ _____

Therapist Name & Signature Date