Joan Forest LICSW

NOTICE OF PRIVACY PRACTICES AND PROCEDURES

Dear Patient:

In compliance with the Healthcare Insurance Portability and Accountability Act (HIPPA) which took effect in April 2003, this office needs to make you aware that all patient information is held in strict confidence and cannot be shared with any party without you written consent.

Your therapist may disclose information only with your written consent to:

1. Your primary care physician or other professional involved in your care.
2. Your attorney, probation officer, or other professional involved in your care.
3. Your insurance company to obtain payment of services rendered.
4. Any other party deemed necessary to provide quality health care.

Your therapist may disclose information without your consent under the following circumstances:

1. You pose a serious threat to yourself or another person.
2. You are directly involved in child or senior abuse/neglect.
3. At the request of a judge or magistrate when "court ordered" to do so. *No LONGER VALID!!!
4. You have failed to provide payment for services or payment of insurance co-pays and/or deductibles per your treatment agreement within 90 days of the services and collection is necessary to secure payment.

You have a right to access of your medical records; however, your therapist may deem direct access harmful to the therapeutic relationship. In some cases a summary may be provided either verbally or in writing. You must make all requests for record access in writing and allow five (5) business days for a response. Your therapist is allowed (10 – 30) business days to provide a summary or a documented reason for refusal. You also have a right to amend your medical record under certain circumstances. If your therapist agrees that the amendment is necessary, your record will reflect these changes, if she/he disagrees, then she/he will provide a justification in writing to the patient and the patient has five (5) days to respond. The therapist will also keep an account of all disclosures made, with the exceptions noted above. *Some people prefer to text regarding appointments only. PLEASE INITIAL IF GIVING PERMISSION TO CORRESPOND USING TEXT_____

When written Release of Information forms are signed, you have a right to rescind this release at any time. This rescind must be made in writing directly to this office.

It is our hope that these procedures will protect your rights and privacy. If you have any questions please ask your therapist directly. You are entitled to a copy of these policies. If you have further questions, please write to: Department of Health and Human Services, 200 Independence Ave., SW, Room 509F, HHH Building, Washington D.C., 20201

_____ _____

Patient Signature Date