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

**Confidentiality**

We understand the information you share in counseling can be very personal. This information about you that may identify you and that relates to your past, present or future physical or mental health is referred to as “protected health information.” This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with applicable law and the AAMFT Code of Ethics. It also describes your rights and how you can gain access to and control your protected health information. As part of your treatment, I will keep some specific information called “psychotherapy notes.” These notes are kept separate from your health record and are given much higher privacy protection. They contain my impressions about you and the details of the psychotherapy conversation I consider to be inappropriate for the health record. They contain information pertinent only to my future work with you. They are not available for your review, nor to insurance and managed care companies.

All clients will be presented with an *Authorization for Release of Confidential Information.* We will only disclose your confidential information to those whom you identify on that form, unless such a release is otherwise authorized or required by law. I am required to provide you with this notice under the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule. Please review it carefully. Let me know if you have any questions or would like additional information. If you do not sign this consent form agreeing to what is in this notice, I cannot treat you.

Your confidentiality/privacy is protected by state law and by the rules of our profession, **EXCEPT** in the following circumstances.

**Required by Law:** There are occasions which require me under law to disclose your protected health information with or without your authorization. Some examples are:

1. If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in anyway necessary to prevent that including contacting family members and the police.
2. If there is suspicion of neglect or abuse of a child in the past, present, or future I am required by law to report that to the Utah Division of Child and Family Services or the police.
3. If you are at risk of being a serious and imminent threat to the health or safety of a person or the public, I will disclose it to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
4. If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Utah Adult Protective Services or the nearest law enforcement agency as soon as I become aware of the situation.
5. Utah law requires that I report the names of any individuals having communicable diseases to the Health Department.
6. If you become involved in the court system a judge can order that I provide information on you. Two examples of this are child custody cases and cases in which clients bring action against therapists.
7. I may disclose your personal health information in accordance with workers compensation laws.

**How I May Use and Disclose Health Information about You**

**For Treatment:** Your protected health information may be used and disclosed to those who are providing, coordinating, or managing your health care treatment and related services. This includes clinical supervisors, or other treatment team members.

**With Your Verbal Permission:** I will only share pertinent information with those you select to be involved with your treatment such as family, close friends, or clergy. Your desire may be to involve other people to support you in the desired outcome of your treatment. You have the right to tell us who to involve, and what information we can disclose to them.

**With Your Written Permission:** I may use and disclose your protected health information after you sign the *Authorization for Release of Confidential Information.* Your information may be used in the following manner: for the coordination of treatment, consultation, assessment and diagnosis, treatment summary and recommendations, psychological or psychiatric assessments, and to obtain medical records and lab results. I will also ask for your written permission before using your information for professional research purposes, and before I videotape or record our counseling sessions.

**For Payment:** I may use and disclose your protected health information so that I can receive payment for the treatment services we provide for you. This will only be done with your written authorization. For example, it may be necessary to disclose your information to: determine eligibility for coverage, process insurance claims, and to determine medical necessity for treatment. If it becomes necessary for me to use collection services due to non-payment for services, I will only disclose the minimum required amount of health information necessary to collect the debt.

**For Health Care Operations:** I may use and disclose your protected health information to support my business activities including, but not limited to, supervision of an employee or intern, quality assessment activities, or other business-related activities such as billing or bookkeeping. If I use a 3rd party to perform any of these business related activities, they are bound by contract to safeguard the privacy of your protected health information.

**Patient’s Rights Concerning Your Protected Health Information:**

1. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction to your request.
2. You have the right to request an amendment of personal health information for as long as we maintain your information in the record. I may deny your request. If so, I will provide you with a written explanation.
3. You have the right to inspect your records, including personal health information, for as long we keep you information in the record.
4. You have the right to request and receive personal health information by alternative means and at alternative locations. For example, I can send your bills to an address other than your home if so requested.
5. You have the right to request an accounting of certain disclosures of personal health information for which you have neither provided consent nor authorization. For example, situations may arise when it is required by law for us to share your personal health information, even without your authorization.
6. You have the right to a copy of this notice, the *Notice of Privacy Practices*.

**Acknowledgement of Receipt of Information Regarding My Care with Alliance Counseling LLC.**

**Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

By signing this document, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby acknowledge that I have received and have read the information contained in the ***Notice of Privacy Practices.***

I have been advised of my rights under the HIPPA Privacy Rule. I understand the limits to confidentiality as required by State and Federal law. I agree to the terms described in this notice. I also understand that if I have any questions about therapy or about my rights as a client, I can ask my therapist or the office manager, Jeremy Bitner, AMFT, and they will do their best to provide answers in timely manner.

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Client Signature (or if a minor, parent signature) Date

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 Witness Signature Date