HIPAA Privacy
Client Rights

As your therapist, I am committed to maintaining your confidentiality. I will abide by state and local laws as well as federal HIPAA policies. These are your rights.

Your right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your clinical record. Your request must be submitted in writing. Under limited circumstance I may release that information to you within a 48 hour period. I may also deny your request to inspect or copy your clinical chart in the event I decide this action would interfere with or negatively impact your treatment. If I agree to your request, for any copy of information, I will charge a reasonable fee for the costs of copying, mailing, and supplies.

Your right to add information or amend your medical records.
You have the right to add or amend your clinical record. This request must be in **writing**, with an explanation for the requested change. I may deny your request to add or amend your information based on clinical judgment. If I deny your request, you have a right to file a statement of disagreement. Your statement and my response will be added to your clinical record.

Your right to an accounting of disclosures.
You may request an accounting of disclosures, if any, that I have made related to your case. There are exceptions to this. They include: information gathered for treatment and treatment planning, payment or health care operational purposes, information that you gave specific consent to release, or that which is required by law.

Your right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be submitted in writing.

Your right to complain.
If you believe your privacy rights have been violated, you may file a written complaint with the U.S. Department of Health and Human Services or the Board of Behavioral Sciences, Sacramento, CA.

Your right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws.

Your right to obtain a copy of this notice

___ I DO wish to receive a copy of this notice ______________________________
Client signature/date

___ I DO NOT wish to receive a copy of this notice ______________________________
Client signature/date

IMPORTANT NOTICE:

Release of some personal information.
In order to access insurance or other 3rd party payer benefits, some of your personal information (name, address, phone #, dates of service, services provided, condition being treated) may be requested by your benefits provider or insurance company. Signing this document does NOT give your permission or consent to release particular session content to anyone. A separate, signed release is required for that purpose.

I understand and consent to the above conditions of treatment.

______________________________	______________________________	____________
Client Signature	Print Client Name	Date