

 **Hippa Policy**

The privacy of your therapeutic/health information is important to us and we are committed to protecting it. On file are the forms you initially completed and records of disclosed as well as your rights.

Notice of Privacy Policy Effective January 1st, 2014

I value you as a client and respect your right to privacy. This notice describes how health information about you may be used and disclosed as well as your rights. This notice of health privacy policy is written in application to conducting a counseling practice.

Use and Disclosure of Your Personal Health Information

There are a number of situations in which I may use or disclose to other persons or entities your confidential health information. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your

Acknowledgement or Authorization. Under any circumstance, I will use or disclose only the minimum amount of information necessary from your health records to accomplish the intended purpose of the disclosure.

Only Under A Signed Release

1. Treatment: It may be necessary to share your health information with another healthcare provider who I may consult with in respect to your care. I ask you to sign a release form. I provide you with the form to complete and sign, and forward to your medical/healthcare provider.
2. Your Authorization: You may give me a written release to use your health information for any purpose that you deem necessary. A release form is given to you to sign. This is revocable, at any time, however you must put in writing.
3. Payment: You may ask me to disclose information about you with your health insurance company concerning claims/payment. You must sign a release form in order for us to do so.

1. Individuals Involved in Your Care or Payment of Your Care: If family members are involved with your care, a signed release form gives permission for health information to be shared or contact calls to be made with them.

Without A Signed Release

1. Proper Authorities: I am required to report to appropriate agencies and law- enforcement officials information if you or a person you tell me about, is in immediate threat of danger to your health, safety or violent activity. I may also be required to report instances of suspected or documented abuse, neglect or domestic violence.

1. Required by Law: Federal, state or local law, or when ordered by a court of law, may require me to use or disclose your health information.

1. Public Health Risks: I may disclose health information about you for public health activities such as to prevent or control disease, injury or disability, or to report reactions to medications or problems with products.

1. Emergency/Notification Contact: Your health record may be used to notify or assist family members, personal representatives or other persons responsible for your care in the event of an emergency or to enhance your well-being or where abouts. I may use and disclose your protected health information if I attempt to obtain your consent yet am unable to do so because of substantial communication barriers. I will also use my sound professional judgment

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Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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