Old Town Professional Psychology, LLC
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HIPAA NOTIFICATION FORM

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. It is being provided to you as required by the Health Insurance Portability and Accountability Act of 1996. Please review it carefully, and feel free to ask me if you have any questions.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations:

With your consent, I may use or disclose your protected health information (PHI) for the purposes of treatment, payment, and health care operations. "PHI" refers to information in your health record that could identify you.

II. Uses and Disclosures Requiring Authorization:

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1)1 have already acted upon the authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization:

Due to ethical and/or legal requirements, I may have to use or disclose PHI without your consent or authorization in the following circumstances:

- Suspected child abuse
- Adult and domestic abuse
- Under subpoena of the Virginia Board of Psychology
- Judicial or administrative proceedings
- If you present as a serious threat to the health or safety of yourself or others:
- If you file a worker's compensation claim

IV. Patient's Rights and Psychologist's Duties;

You have the right to:

- Request restrictions on certain uses and disclosures of protected health information about you.
- Receive confidential communications by alternative means and at alternative locations.
- Inspect and copy your records. (I may deny this request in certain circumstances).
- Request an amendment of your records.
- Receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice).
- Obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with written notice, delivered during our regularly scheduled sessions or by mail.

V. Questions and Complaints:

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to the above address. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy:

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If I make any changes, I will provide you with written notice, delivered either in our sessions or by mail.

I have read the HIPAA notification form.

_____ _____

Signature of Client/s or Parent Date

_____ _____

Witness Date