NOTICE OF PRIVACY PRACTICES

Please read through the information below carefully and initial at the bottom indicating that you have read and understood the information contained in this notice.
Federal law requires me to give you this notice, and it is known as the Heath Insurance Portability and Accountability Act (HIPPA).
This notice will tell you about the ways in which I may use and disclose health information about you and will describe your rights and my obligations regarding the use and disclosure of that information.

Your Health Information:

This notice applies to the information and records we have about your health, health status, and the health care services you receive.
This information and record relates primarily to counseling services you will receive from me.

How We May Use and Disclose Health Information About You:

For Treatment
Elaine K. Shepherdson may use or disclose health information about you to facilitate counseling and other health treatment. For example, I may disclose information about you to another therapist to determine the most appropriate care for you.
For Payment
Elaine K. Shepherdson may use or disclose health information about you so that I can be paid by you, or any other party, if they are paying any portion of the fee for the services I provide for you.
For Operations
Special Situations
Elaine K. Shepherdson may use or disclose health information without your permission for several reasons. These reasons include:

Disclosing your health information in order to prevent a serious threat to your health and safety or the health and safety of another person.

Disclosing your health information as required by law to prevent injury or suspected abuse or neglect.

Disclosing your health information as required by federal, state or local law.

Disclosing your health information in response to a court order, subpoena, warrant, summons or similar process.

Other Uses and Disclosures of Health Information
Except where otherwise required or authorized by law, I will not use or disclose your health information for any purpose without your written authorization. If you authorize me to use or disclose health information about you, you may revoke your authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose your health information for the reasons covered by your written authorization, but I cannot take back any uses or disclosures I have already made with your permission.

Your Rights Regarding Your Health Information:

You may inspect and copy your health information, with certain exceptions.

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information.

You may obtain an accounting of our disclosures of your health information. This is a list of all our disclosures of your health information for the purposes other than treatment, payment and health care operations.

You may request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail.

You have the right to receive a paper copy of this notice.

If you want to exercise any of these rights, please let your therapist know with a written request at any time.

I have the right to change this notice. If I do so, the new notice will apply to the health information we may already have about you and to the health information that we receive in the future. I am required to abide by the most current notice that is in effect. You are entitled to receive a copy of the most current notice.

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

_____
Client Initials