NOTICE OF PRIVACY PRACTICES

This notice describes how health care and medical information about you may be used and disclosed. Please review it carefully. WHO WILL FOLLOW THIS NOTICE: The "designated privacy officer" is Zach Lehman, LCSW.

YOUR HEALTH INFORMATION:

This notice applies to the information and records I have regarding your health, health status, and the healthcare and services you receive at this office.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

I must have your written, signed consent to use and disclose health information for the following purposes:

1. For Treatment. I use health information about you to provide mental health treatment or services.

2. To assist you in obtaining authorization for service from your insurance provider.

3. For Payment of Services. I may use and disclose health information about you so that the treatment and services you receive may be billed to and payment may be obtained from you, an insurance company, or a third party.

You may revoke your consent at any time by providing written notice. Your revocation will be effective on the date and at the time it is received, but will not apply to any uses and disclosures that have occurred before that time. If you revoke your consent, I will not be permitted to use or disclose your information for purposes of treatment, authorization, or payment, and may choose to discontinue providing services to you at that time.

SPECIAL SITUATIONS:

I may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. Prevention and/or intervention in the event of a Serious Threat to Health or Safety. I may use and disclose health information about you when in my professional judgment it is necessary to prevent or intervene in a serious threat to your health and safety, or to the health and safety of another person or the general public.

2. As Required by Law. I will disclose health information about you when required to do so by federal, state, or local law.

3. Workers' Compensation. With your written consent, I may release health information about you for workers' compensation or similar programs.

4. Reporting of Suspected Abuse or Neglect. Under Virginia law, I must report to Child Protective Services any allegations or evidence of unreported and/or suspected child abuse or neglect which is alleged to be currently occurring or has allegedly occurred at any time in the past.

5. Health Oversight Activities. I may disclose health information to a health oversight agency for the purpose of audits, investigations, inspections, or licensing purposes. These disclosures may be required for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

6. Law Enforcement. I may also release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.

7. Coroners, Medical Examiners, and Funeral Directors. I may release health information to a coroner or medical examiner, for example, if deemed necessary to aid in the identification of a deceased person or to determine the cause of death.

8. Information Not Personally Identifiable. I may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

9. OTHER USES AND DISCLOSURES OF HEALTH INFORMATION I will not use or disclose your health information for any other purpose other than those identified in the previous sections without your written authorization. I must obtain this authorization separate from any consent I may have already obtained from you. If you give me authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose information about you for the reasons covered by that written authorization, but I cannot take back any disclosures already made with your permission.

If I have medical information about you regarding HIV or substance abuse I cannot release that information without a special signed, written authorization (different from the authorization and consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment, or healthcare operations, I must have both your signed consent and your written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information I maintain about you:

1. Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that I use to make decisions about your care. You must submit a written request to me in order to inspect and/or copy your health information. If you request a copy, I may charge a fee for the costs of copying, mailing, or other associated supplies. I may require that the requested information be reviewed with me prior to its release. I may deny the request to inspect or copy information in certain limited circumstances. If you are denied access to your health care information, you may ask that the denial be reviewed by a licensed psychiatrist. If such a review is required by law, I will comply with the outcome of this review.

2. Right to Amend. If you believe that health information I have about you is incorrect or incomplete, you may request in writing to amend the information. You have the right to request an amendment for as long as I maintain your records. To request an amendment, submit a Medical Record Amendment/Correction Form to me. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request to amend information I did not create (unless the person/entity that created the information is no longer available to make the amendment), that is not part of the health record I maintain, that you would not normally be permitted to inspect and copy, or in a manner that is factually inaccurate and/or incomplete.

3. Right to Accounting Disclosures. You may request a list of any authorized disclosures I have made of medical information about you for purposes other than treatment, payment, and healthcare operations. To obtain this list please submit this request to me in writing. It must state a time period which may not be longer than six years and may not start before January 1, 2012. Your request should state that you want this list in writing. I will notify you of any charge for the costs of providing this list so that you may choose to withdraw or modify your request before any such costs are incurred.

4. Right to Request Restrictions. You may request in writing a restriction or limit on the health information I use or disclose about you for treatment, payment, or healthcare operations. You may also request a specific limit on the health information I disclose about you to someone who is involved in your care or the payment for it. I am not required to agree to your request if I think it will cause danger or harm to any person. If I do agree, I will comply with your request unless the information is necessary to provide you with emergency care.

5. Right to a Paper Copy of This Notice. You may ask me for a copy of this notice at any time. To obtain one, please contact me.

CHANGES TO THIS NOTICE:

I reserve the right to make changes to this notice at any time, and you will be informed of any changes to this notice. You may also request a copy of the current notice by contacting me.

COMPLAINTS:

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