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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

MY PLEDGE REGARDING HEALTH INFORMATION

I understand that health information about you and your health is personal. I am committed to protecting your privacy and health information about you. I create a record of the care and services that you receive. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by me. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

This notice will tell you about the ways in which I use and disclose health information about you. I describe your rights and certain obligations I have regarding the use and disclosure of health information.

I am required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of my legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what is meant and try to give some examples. Not every use or disclosure in a category will be listed.

For Treatment. I may use health information about you to provide you with treatment or services. I may disclose information about you to doctors, nurses, clinicians, case managers, interns , or other agency personnel who are involved in providing services to you. For example, I may need to talk with another clinician who has specialized training in a particular area of care. I may also disclose information about you to

people outside my office who are involved in your health care such as a school social worker or guidance counselor.

For Payment. I may use and disclose health information about you so that the treatment and services you receive may be approved by, billed to, and payment collected from a third party such as an insurance company or developmental services funding committee. For example, I may need to give your health plan information about counseling you received by me so your health plan will pay me or reimburse you for a counseling session. I may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the service/treatment.

Appointment Reminders. I may use and disclose information to contact you as a reminder that you have an appointment.

Alternative Treatment and Benefits and Services. I may use and disclose information about you in order to obtain and recommend to you other treatment options and available services as well as other health-related benefits or services.

As Required by Law. I will disclose medical information about you when required to do so by federal, state or local law. In Vermont, this would include: victims of child abuse; the abuse, neglect or exploitation of vulnerable adults; or where a child under the age of sixteen is a victim of a crime; and firearm-related injuries.

To Avert a Serious Threat to Health or Safety. I may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans. If you are a member of the armed forces, I may release health information about you as required by military command authorities.

Workers' Compensation. I may release health information about you as authorized for worker's compensation or similar programs as authorized by Vermont law. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks. I may disclose health information about you for public health activities. These activities include the following:

- To prevent or control disease, injury or disability;
- To prevent deaths;
- To report child abuse or neglect;

- To report abuse, neglect or exploitation of vulnerable adults; any suspicion of abuse, neglect, or exploitation of the elderly (age 60 or older), or a disabled adult with a diagnosed physical or mental impairment, must be reported;
- To report reaction to medications or problems with products;
- To notify individuals of recalls of products they may be using;
- To notify an individual who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Health Oversight Activities. I may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, but are not limited to: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Legal Proceedings and Disputes. If you are involved in a lawsuit or dispute, I may disclose health information about you in response to a court or administrative order.

Public Health Officials and Funeral Home Directors. I may release information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. I may also release health information to funeral directors thereby permitting them to carry out their duties. If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

By signing this form, I consent to the therapist's use and disclosure of protected health information about me for treatment, payment and health care operations. I understand that I may revoke this consent in writing, except that the therapist has already taken action based upon my prior consent.

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Name of Individual Receiving Services (please print)

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Signature of Individual Receiving Services or Legal Representative

_____

Witness

_____

Date