**Health Insurance Portability Accountability Act (HIPAA): Client Rights & Therapist Duties**

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), and your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time.

**LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others by your written authorization. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, and may reveal some treatment information:

1. If I know or have reason to suspect that a minor child or vulnerable adult has been abused, abandoned, or neglected the law requires that I file a report with the Oklahoma Abuse Hotline.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Oklahoma Abuse Hotline
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

**CLIENT RIGHTS AND THERAPIST DUTIES**

**Use and Disclosure of Protected Health Information:**

* ***For Treatment* –** We use and disclose your health information internally at Stillwater Counseling Center, PLLC in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Further, an authorization is required for most uses and disclosures of psychotherapy notes.
* ***For Payment*** – We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.
* ***For Operations*** – We may use and disclose your health information within the organization as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

**Patient Rights:**

* ***Right to Confidentiality and to Request Restrictions***– You have the right to have your health care information protected. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
* ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations***
* ***Right to Inspect and Copy*** *–* You have the right to inspect or obtain a copy (or both) of certain PHI. Records must be requested in writing and release of information must be completed at least two weeks in advance. Furthermore, there is a copying fee charge of $1.00 per page. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
* ***Right to Amend*** *–* If you believe the information in your records is incorrect and/or missing important information, you can request, in writing, to make certain changes. If your request is denied, we will tell you why within 60 days.
* ***Right to a copy of this notice***
* ***Right to an Accounting*** *–* You generally have the right to receive an accounting of disclosures of PHI.
* ***Right to choose someone to act for you***
* ***Right to Choose*** *–* You have the right to decide not to receive services with me or to terminate services at any time. If you wish, I will provide you with names of other qualified professionals.
* ***Right to Release Information with Written Consent***

**Therapist 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 a revised notice in office during our session.

**COMPLAINTS –**If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Oklahoma Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

*YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.*

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Client/Legal Guardian Signature Printed Name Date

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Client/Legal Guardian Signature Printed Name Date

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SCC Counselor Date