



# Notice of Privacy Practices

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

I keep a record of services provided to you to ensure quality care and to comply with the law. These records and other health information about you are protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Counseling Association's [Code of Ethics](#), and all applicable statutes and administrative rules regulating the practice of counseling or therapy or any other applicable laws. Below is a summary of my responsibilities, your rights, and examples of uses and disclosures.

## My Responsibilities

- I am required by law to maintain the privacy and security of your protected health information.
- I will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you provide me with written permission. You may revoke this permission at any time by notifying me in writing.

## Your Rights

When it comes to health information created by my practice, you have the following rights:

- Get an electronic or paper copy of your health record.
  - You can ask to see or get an electronic or paper copy of your health record and other health information my practice has about you.
  - Unless there are ethical reasons not to, I will provide you with a copy of your record, or a summary of it, if you prefer, within 30 days of receiving your written request.

- You can also request assistance in interpreting your records if needed.
- Ask me to amend your health record.
  - You can ask me to amend health information about you that you think is incorrect or incomplete. I may decline your request, but I'll explain why in writing within 60 days.
- Request confidential communications.
  - You can ask me to contact you in a specific way (for example, by phone or email) or to send mail to a different address, and I will agree to all reasonable requests.
- Ask me to limit what I use or share.
  - You can ask me not to use or share certain health information for treatment, payment, or my operations. I am not required to agree to your request, and I may decline if it would affect your care.
- Choose someone to act for you.
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - I will make sure the person has this authority and can act for you before I take any action.
- Get a copy of this privacy notice.
  - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.
- Get a list of those with whom I've shared information.
  - You can ask for a list of the times I've shared your health information for six years prior to the date you ask, whom I shared it with, and why.
  - I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make).
- File a complaint if you feel your rights are violated.
  - If you feel I have violated your rights, you can complain by contacting me using the information at the beginning or end of this notice.
  - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)
  - I will not retaliate against you for filing a complaint.

## Your Choices

For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, tell me and I will follow your request:

- Sharing information with your family, close friends, or others involved in your care, and
- Sharing information in a disaster relief situation.

If you are unable to tell me your preference—for example, if you are unconscious—I may share your information if I believe it is in your best interest.

## Typical Uses And Disclosures

I typically use or share your health information:

- To treat you.
  - I can share your information with other professionals who may help me treat you.
  - When sharing with other providers, I always share only the minimally necessary amount of information required. Your information always remains confidential and unable to be identified unless I have your written consent to share otherwise.
- To run my practice.
  - I can use and share your health information to run my practice and contact you when necessary, such as sending you intake forms or appointment reminders.
- To bill for services.
  - I can use and share your health information to bill you or a third party for services rendered.

## Other Uses And Disclosures

I am allowed or required to share your information in other ways and must meet certain conditions before doing so. Even though I am not required by law to obtain your permission to share information in these cases, I always prefer to do so if possible.

Your information may be disclosed to:

- Comply with the law.
  - I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I'm complying with federal privacy law.

- I will share information in order to cooperate with investigations, proceedings, and requirements of the American Counseling Association Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation.
- Report suspected abuse of children or vulnerable adults.
  - Abuse reports typically must be made within a very short time frame. I will attempt to notify you before making such reports but cannot always guarantee this.
- Report imminent danger to you or others.
  - If you are at imminent risk of harming yourself, I may be required to disclose your information in order to intervene, such as notifying law enforcement.
  - If you disclose that you intend to commit a crime or harmful act against someone, I may be required to take appropriate action, which may include warning potential victims or notifying law enforcement.
- Respond to lawsuits and legal actions.
  - I may be required to share health information about you in response to a court or administrative order, or in response to a subpoena. If I am ordered to do so without your permission, I will seek to obtain written, informed consent from you or take steps to prohibit the disclosure or have it limited as narrowly as possible because of potential harm to you or our counseling relationship.
  - I am allowed to share information to defend claims brought by you against me.

## Nondisclosures

I will never sell your health information or use or disclose it for marketing purposes. I also do not manage a hospital directory which could include your information.

## Psychotherapy Notes

In order to better assist you, I may keep optional *psychotherapy notes*, which document or analyze the contents of counseling sessions, and are not part of your health record. Most sharing of any of these notes requires your written permission.

## Contact Information

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## Changes to the Terms of this Notice

I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request and on my website. For more general information about this kind of notice visit:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

*This notice is effective as of April 25, 2025.*

**BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I HAVE RECEIVED A COPY OF THIS NOTICE.**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_