TRANSCEND COUNSELNG

8919 George Washington Memorial Highway

Yorktown, VA 23693

757-570-1677, 276-644-5283(fax)

NOTICE OF PRIVACY RIGHTS

CONFIDENTIALITY

Uses and Disclosures of Information Requiring your Authorization or Consent

As a rule, we will disclose no information about you, or the fact that you are a patient, without your written consent. Your chart contains information that describes the services provided to you and contains the dates of your sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, we do not routinely disclose information in such circumstances, so we will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

LIMITS OF CONFIDENTIALITY

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality. To receive mental health services, you must sign the attached form indicating that you understand and accept the policies about confidentiality and its limits. We will discuss these issues now; you may reopen the conversation at any time during our work together. We may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

* **Emergency**: If you are involved in in a life-threatening emergency and we cannot ask your permission, we will share information if we believe it will be helpful to your welfare.
* **Child Abuse Reporting**: If we have reason to suspect that a child is abused or neglected, we are required by Virginia law to report the matter immediately to the Virginia Department of Social Services.
* **Adult Abuse Reporting**: If we have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, we are required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.
* **Serious Threat to Health or Safety**: Under Virginia law, if you communicate a specific and immediate threat to cause serious bodily injury or death, to an identified person, and you have the intent and ability to carry out that threat immediately or imminently, we are legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. We may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, we can be required to provide your records to the magistrate, your attorney or guardian *ad litem*, a CBH evaluator, or a law enforcement officer, whether you are a minor or an adult.
* **Health Oversight**: Virginia law requires that licensed psychologists [social workers/counselors] report misconduct by a health care provider of their own profession. By policy, we also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, we are required to explain to you how to make such a report. If you are yourself a health care provider, we are required by law to report to your licensing board that you are in treatment and if your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.
* **Court Proceedings**: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information unless you provide written authorization, or a judge issues a court order. If we are subpoenaed for records or testimony, we will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, we are required to place said records in a sealed envelope and provide them to the Clerk of Court. In Virginia civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if we do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
* **Workers Compensation**: If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
* **Health Insures/ Collection Agents**: disclosures required by health insurers or to collect overdue fees as discussed elsewhere in the agreement.
* **Records of Minors**: Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CBH evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if we provide services to minors. [For adolescents in psychotherapy, also see Sample Adolescent Consent Form, to be signed by minor and parent]. Other uses and disclosures of information not covered by this notice or by the laws that apply to Transcend Counseling will be made only with your written permission.

PATIENT RIGHTS AND PROVIDER DUTIES

* **Right to Request Restrictions**: You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. If you ask us to disclose information to another party, you may request that we limit the information we disclose. However, we are not required to agree to a restriction of your request. To request restrictions, you must make your request in writing, and tell your counselor: 1) what information you want to limit; 2) whether you want to limit the use, disclosure, or both; and 3) to whom you want the limits to apply.
* **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations**: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen. Upon your request, we will send your bills to another address. You may also request that we contact you only at work, or that we do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
* **Right to an Accounting of Disclosures**: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in this section of this Notice). On your written request, we will discuss with you the details of the accounting process.
* **Right to Inspect and Copy**: In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, we may charge a fee for costs of copying and mailing. We may deny your request to inspect and copy in some circumstances. We may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
* **Right to Amend**: If you feel that the protected health information we have about you is incorrect or incomplete, you may ask to amend the information. To request an amendment, your request must be made in writing, to the office. In addition, you must provide a reason that supports your request. This request may be denied if: 1) was not created by us; we will add your request to the information record; 2) is not part of the medical information kept by us; 3) is not part of the information which you would be permitted to inspect and copy; or 4) is not accurate or incomplete.
* **Right to a copy of this notice**: You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Changes to this notice: we reserve the right to change my policies and/or to change this notice, and to make changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. We will have copies of the current notice available on request.
* C**omplaints**: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to the office. You may also send a complaint to the U.S. Department of Health and Human Services.

**Client's Acknowledgement of Receipt of Notice of Privacy Practices**

I have been provided a copy of Transcend Counseling's Notice of Privacy Practices. We have discussed these policies, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services.



Client/Parent/Guardian Signature Date



Printed Name of Client/Parent/Guardian Representative



Description of Personal Representative’s Authority (mother/father/guardian)



Provider/Witness Date