Notice of Privacy Practices (Brief Version)

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 commitment to your privacy:

As part of providing professional services to you, I will do all I can to maintain the privacy of what is called your "protected health information" (PHI). I am also required by law to keep your PHI private. These laws are complicated, and I must give you this important information. This document is a shorter description of what I do to maintain your privacy. If you would like to read the more detailed version, please ask me for a copy. If you have any questions about my privacy practices, please let me know.

How I use and disclose your protected health information (PHI) with your consent:

I will use the information I collect about you mainly to provide you with treatment; to arrange payment for our services; and for some other business activities called, in the law, "health care operations." I will ask you to sign a separate consent form to show that you understand these ways I handle your information. If you do not agree and won't sign this consent form, I will not be able to treat you. If I want to use or send, share, or release your PHI for other purposes, I will discuss this with you so you fully understand it, and ask you to sign a release-of-information form (ROI) to allow this.

Disclosing your health information without your consent:

There are some times when the laws require me to share your information without getting your consent. They are described in the longer version of our Notice of Privacy Practices, but here are the most common situations:

1. When there is a serious threat to your or another person's health or safety or to the public. I will only share information with people who are able to help prevent or reduce the danger.
2. When I am required to do so by lawsuits and other legal or court proceedings.
3. When a law enforcement official requires me to do so.
4. When I become aware of potential abuse or neglect of a child, elderly person, or disabled person.
5. For workers' compensation and some similar programs if you apply for these benefits.

Your rights about your health information:

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, rather than at work, to schedule or cancel an appointment. I will try my best to do as you ask.
2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information I have about you, such as your medical chart and billing records. You can get a copy of these records, and I can charge you for copies of your record. Please talk to me to arrange how to see your records.
4. If you believe that the information in your record is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing and send it to me.
5. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the care I provide to you in any way.
6. You have the right to a copy of this notice.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations or answer any questions now or as they arise. My contact information: 360-382-2158 brentbelfordlcsw@gmail.com

The effective date of this notice is __1__/__1__/__25__.

Consent to Use and Disclose Your Health Information

By signing below I acknowledge that I have been provided a copy of the Notice of Privacy Practices (NPP), and I consent to the use of my health information under the terms described in the NPP. I understand that I may revoke my consent at any time by providing written notice.

_____ _____

Signature Date

_____ _____

Print Name Date