

*Cathy Battle, EdS, LMFT, LPC*

*Counseling*

*8014 Myrtle Trace Drive*

*Conway, SC 29526*

*843 347-5239 phone/fax*

*www.imagosouthcarolina.com*

## **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

-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.

-All information revealed by you in a counseling or therapy session and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered “protected health information” by HIPAA. As such, your protected health information *cannot be distributed to anyone else without your express informed and voluntary written consent or authorization.*

-The exceptions to this are defined below.:

**Use or disclosure of the following protected health information does not require your consent or authorization:**

1. Uses and disclosures required by law - *like files court-ordered by a Judge*
2. Uses and disclosures about victims of abuse, neglect, or domestic violence - *like the Duties to Warn explained in your therapist’s/counselor’s Disclosure Statement*
3. Uses and disclosures for health and oversight activities - *like correcting records or correcting records already disclosed*
4. Uses and disclosures for judicial and administrative proceedings - *like a case where you are claiming malpractice or breach of ethics*
5. Uses and disclosures for law enforcement purposes - *like if you intend to harm someone else (see Duties to Warn in your therapist’s/counselor’s Disclosure Statement)*
- 7 Uses and disclosures for research purposes - *like using client information in research; always maintaining client confidentiality*

8. Uses and disclosures to avert a serious threat to health or safety - *like calling Probate Court for a commitment hearing*

9. Uses and disclosures for Workers' Compensation - *like the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim*

**Your Rights as a Counseling/Therapy Client under HIPAA:**

– As a client, you have the right to see your counseling/therapy file.

*Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.*

– As a client, you have the right to receive a copy of your counseling/therapy file. This file copy will consist of only documents generated by us. You will be charged copying fees @ \$.20/page. *Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.*

– As a client, you have the right to request amendments to your counseling /therapy file.

– As a client, you have the right to receive a history of all disclosures of protected health information. You will be charged copying fees @ \$.20/page.

– As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations.

- If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.

– As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

-Prior to your counseling or therapy, you will receive 1.) an exact duplicate of these two pages and 2.) your therapist's/counselor's Professional Disclosure Statement and Consent for Treatment - both for your personal records. It will be necessary for you to sign a certificate indicating that you have received, read, and understand both documents. This certificate will be placed in your counseling/therapy file.

Please do not sign the certificate if you do not understand

any part of the HIPAA Client's Rights or the Professional Disclosure Statement and Consent for Treatment. Your counselor or therapist will be happy to explain these documents further.

Thank You !

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I acknowledge that I have received and read the ***Cathy Battle Counseling Professional Information and Consent for Treatment*** and the ***HIPAA Client's Rights***. I further acknowledge that I seek and consent to treatment with Cathy Battle. My signature below confirms that I understand and accept all the information contained in the ***Cathy Battle Counseling Professional Information and Consent for Treatment*** and the ***HIPAA Client's Rights***.

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Signature of Client

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Date