



HIPAA Notice of Privacy Practices
Effective 4/13/03, updated 11/17/06

Patient's Name: _____ **SSN#:** _____

This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

Uses and Disclosures of Your Protected Health Information

Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

Payment: I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

Health Care Operations: I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. I may use your PHI when leaving messages to follow-up on or confirm appointments, unless you have directed me not to do so.

Required by Law: Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are these:

- You seriously threaten to hurt yourself or someone else.
- I am subpoenaed to do so by the courts.
- I receive information that a child or vulnerable adult has been abused or neglected.

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Verbal Permission: I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me:

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. You will be charged \$.25 for each page copied & you will be expected to pay for the copies at the time you pick them up.
- Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I am not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

Complaints

If you believe I have violated your privacy rights, you have the right to file a complaint in writing to:

Texas State Board of Social Work Examiners, Complaints Management and Investigative Section, P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. I will not retaliate against you for filing a complaint.

More Information

If you have any questions and would like additional information you should bring this to my attention at the first opportunity. I am the designated Privacy Officer for my practice, and will be glad to respond to your questions or request for information.

Client or Parent/Guardian signature date

Robyn Gobbel, LCSW date

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Acknowledgment of Receipt of Notice of Privacy Practices

By my signature below, I, _____, acknowledge that I received a copy of the Notice of Privacy Practices of Gobbel Counseling & Adoption Services, PLLC.

Signature of client or personal representative (parent/guardian)

Date

Printed name

Relationship to client

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