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NOTICE OF PRIVACY PRACTICES:

This notice involves your privacy rights and describes how information about you may be disclosed, and how you can obtain access to this information.
Please review it carefully.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and Intake or other forms filled out by you. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes, however, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship 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.
I cannot guarantee the confidentiality of any e mail correspondence.

II. Limits of Confidentiality

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

I 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 a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Florida law to report the matter immediately to the Department of Children and Family Services.

Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Florida law to immediately make a report and provide relevant information to the appropriate State agency.

Court Proceedings:

By signing this document, you also understand that this is an agreement that no client shall attempt to subpoena my testimony or my records for a deposition or court hearing of any kind for any reason.
All clients acknowledge that the goal of psychotherapy is the amelioration of psychological distress and interpersonal conflict, and that the process of psychotherapy depends on trust and openness during the therapy sessions.
Therefore, it is understood by all clients that if they request my services as a psychotherapist, they are expected not to use information given to me during the therapy process for their own legal purposes or against any of the other parties in a court or judicial setting of any kind.
Now having said this, if I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. Ultimately, the judge will make the decision.
If I am subpoenaed, the client will be billed at my hourly rate.

Serious Threat to Health or Safety:
Under Florida law if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am 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.

III. Patient's Rights and Provider's 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 I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing and tell me: 1) what information you want to limit; 2) whether you want to limit my 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 seeing me. You may request that I contact you only

at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request verbally or in writing, specifying how or where you wish to be contacted.

Right to a Copy of this Notice: You have the right to a paper copy of this notice. I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I 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. I will have copies of the current notice available on request.

EFFECTIVE DATE: _____