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Notice of Privacy Practices

This notice, and the accompanying **Practices Regarding Disclosure of Patient Health Information**, describes how health information about you may be used and disclosed, and how you can get access to your health information. A copy is given to all individuals receiving care. Please review this information carefully.

Understanding your health record: A record is made each time you visit this therapy office (Judith Silvan, LICSW, herein referred to as "this practice"). Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and to make informed decisions about who, what, when, where, and why others may be allowed access to you health information.

Understanding your health information rights: Your health record is the physical property of this practice, but the content is about you. You have the right to review and obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternative means or to alternate locations.

Our responsibilities: This practice is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosures of your health information to others. This practice reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, this practice agrees not to use or disclose your health information without your authorization.

TO RECEIVE ADDITIONAL INFORMATION OR TO REPORT A PROBLEM, you may contact me directly. If +you believe you privacy rights have been violated, you have the right to file a complaint with us/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

I, _____, have received a copy of the **Notice of Privacy Practices** and the accompanying **Practices Regarding Disclosure of Patient Health Information**. I understand my health information will be used and disclosed consistent with these Notices.

Client/Patient Signature: _____

Date: _____

Signature of Witness: _____

Date: _____