Wendy Byrd, MA, LPC, LMFT

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
PLEASE READ THIS NOTICE CAREFULLY

Your health records contain 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) in accordance with applicable law. It also describes your rights regarding how we may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

FOR 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 care, treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

FOR PAYMENT: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities**. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for the purposes of collection.**

FOR HEALTH CARE OPERATION: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g. billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI, to remind you of appointments, to provide information about treatment alternatives or other health related benefits and services, or for facility directories.

REQUIRED BY LAW: Under the law, we must make disclosures of your PHI to you upon request, In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule. **It is the practice of this office to obtain your authorization for disclosures of information. It is also your right to know that the following are examples where disclosures can and will be used, if necessary, without your authorization:**

Abuse and Neglect, Judicial and Administrate, Proceedings Deceased Persons, Emergencies, Family involvement in care, Health Oversight, Law Enforcement, National Security, Public Health, Research, Public Safety (Duty to Warn)

WITHOUT AUTHORIZATION: Applicable law and ethical standards permit us to disclose information about you without authorization only in a limited number of situations. The types and uses and disclosures that may be made without your authorization are those that are:

1) Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as Licensing Boards of Professional Counselors, Marriage & Family Therapists or the Health Department.)
2) Required by Court Order
3) Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

VERBAL PERMISSION: We 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 REGARDING YOUR PHI: You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Wendy Byrd , LMFT, LPC, 9501 Capital of Texas Hwy, suite 104.

Right to Access to Inspect and Copy. You have the right, which may be restricted, 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. We may charge a reasonable, cost based fee for the copies.

1) **Right to Amend:** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.

2) **Right to an Accounting of Disclosures:** You have the right to request an accounting of certain of thee disclosures that we make of your PHI. We may charge you a reasonable fees if you request more than one accounting in any 12-month period.

3) **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. We are not required to agree to your request.

4) **Right to request Confidential Communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

NAME: **BIRTH DATE:**

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of Privacy Practices or my privacy rights. I can contact Wendy Byrd, MA, LMFT, LPC at, 9501 Capital of Texas Hwy Suite 104, Austin, TX 78759 and (512) 350-8015. ***My signature below acknowledges that I have signed two copies of this form; one copy for me to keep and one copy for my client file with Wendy Byrd, MA, LMFT, LPC.***

_____ _____
Client Signature Date

_____ _____
Signature of Parent, Guardian or Representative Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (Power of attorney, healthcare surrogate, etc.)