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HIPAA 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.

The Health Insurance Portability and Accountability Act (HIPAA, 2003 and as currently amended), requires that every consumer of healthcare services, to include mental health services, be duly notified at the onset of treatment (unless clinically contraindicated), of the use and disclosure of your Private Health Information (PHI) for treatment purposes, insurance reimbursement and payment, and healthcare operations.

The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature, acknowledging that I have provided you with this information. We can discuss any questions you have about the process.

I. Confidentiality

As a rule, I will not disclose information about you, or the fact that you are my patient, without your express written consent. Your ‘record’ will contain information about the services that I provide to you, and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports or medical documentation legally obtained from yourself or other providers. 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 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.

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. In addition to a verbal disclosure, a report may have to be filed with the appropriate state or federal agency/authorities.

1. If I have cause to believe that you intend to harm yourself or end your life
2. If I have cause to believe that you intend to harm someone else
3. If you disclose that you have been the victim of child abuse as a minor (in the State of Maryland, even past abuse of a minor must be reported even if that person is no longer a minor)

4. If I believe that you are actively abusing a minor child or elderly person
5. If you make a threat against national security (to include property, the President, any member of Congress), etc.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may issue a Court Order compelling my testimony if he/she determines that the issues demand it. Under this condition, I am obligated to testify or to produce records.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

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 your PHI. 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 any 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. Upon your request, I will send your bills to another address. You may also 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 in writing, specifying how or where you wish to be contacted.

Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I charge a fee for the costs of copying and mailing, consistent with the law. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

Right to Amend – You have the right to request that I amend the information contained in your record. To request an amendment, your request must be submitted to me in writing. In addition, you must provide a reason that supports your request. Your request may be denied if you ask me to amend

information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

Right to a copy of this notice – You have the right to a paper copy of this notice upon your request, though you can access it on my website at any time.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

Patient’s Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Dr. Nicole Alford’s “Notice of Privacy Practices”
We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature: _____

Printed Name: _____

Date: _____