NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

Our Commitment

By my signature below, I consent to the use or disclosure of my mental health information in order that Insights group therapists may carry out treatment, payment, or mental health care operations. This relates to any and all mental health care services provided by your therapist, including, without limitation, information relating to services provided prior to this date.

Your Mental Health Care Rights

Although your health record is the physical property of your therapist, you have the right to: access information, request amendments, an accounting of disclosures, request privacy restrictions, request alternative communication, file complaints, obtain a detailed copy of this notice. Please refer all requests to your therapist. I understand that the practice may change the terms of the Notice from time to time and that I may contact the my therapist to obtain a revised version of the Notice at any time.

Amend and Restrict Information

If you feel that the medical or mental health information we have is incorrect or incomplete, you may ask us to amend, or add to or restrict the information. You have the right to request an amendment for as long as the information is kept by the practice. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial in writing. In the event that the practice does agree to the requested restriction, it will be binding on the practice. You have the right to request a limit on the medical/mental health information we release about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, but will do so if it is reasonable.

Request Confidential Communications

You have the right to request an accounting of disclosures of medical/mental health information about you. This does not include disclosures for treatment, payment, operations, or to you or your authorized representative. You have the right to request that we communicate with you about medical/mental health matters. We will agree to the request to the extent that it is reasonable for us to do so. We reserve the right to contact you by other means and at other locations if you fail to respond to communication from us.

Receiving Paper Copies and Disclosures

You have the right to receive an accounting of disclosures of protected health information that will be available for a six-year period beginning with the date of the first initial visit. You have the right to receive a paper copy of this notice. Your therapist is required by law to maintain the privacy of protected mental health records and provide individuals with notice of his/her legal duties and privacy practices with respect to protected health information. Your therapist is required to abide by the terms of this Notice.

Complaints

If you believe your privacy rights have been violated; you may file a complaint with us by contacting your therapist, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

I understand that if I refuse to sign this consent or if I revoke this consent in the future, that this Practice will not provide any treatment to me or arrange for treatment on my behalf, and may discharge me as a client, to the extent permitted by law.

_____ _____

Signature of Client (or Personal Representative) Date

_____ _____

Printed Name of Client (or Personal Representative) Relationship to Client