Notice of Privacy Practices
EFFECTIVE APRIL 14, 2003

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 read it carefully.

I have a duty to maintain privacy of your health information and to provide you with this notice. You will be asked to sign a Consent Form. Once you have signed the Consent Form, I may use or disclose your Protected Health Information for purposes of diagnosis, treatment, obtaining payment, or to conduct healthcare operations. For example, if you choose to use insurance, to receive payment I must provide information about you to your insurance company.

When I have your written permission. If you give me written permission to use or disclose your health information to someone else, I will use or disclose it according to your instructions. You may revoke your permission, in writing, at any time, except to the extent that we have already used or disclosed the information that you gave us permission to use or disclose.

When I do not have your written permission. Sometimes I will disclose information without your permission. For example, if you choose to use insurance, to receive payment I must provide information about you to your insurance company.

Required by Law. We will disclose health information about you when we are required to do so by a federal, state, or local law or regulation. Here are the following examples of when I am required to do so by law:

Abuse or Neglect: If I suspect abuse or neglect of a child or elder, I am mandated to make a report to the appropriate public authorities.

Danger: If I suspect you are in imminent danger or harming yourself or someone else, I am mandated to make a report to the person at risk and to the public authorities.

Legal Proceedings: I may disclose Protected Health Information in response to a court order or subpoena or in certain other legal proceedings.

Your Rights Regarding Health Information About You

You have the following rights regarding the health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy health information that I maintain about you as allowed by state and federal law. If you request a copy of your information in writing, I may charge a fee for copying, labor, supplies and mailing. I must respond within 15 days of the receipt.

Right to Amend. If you feel that health information that I have about you is incorrect or incomplete, you may ask me to amend, or correct, the information. You have the right to request an amendment for as long as the information is kept by or for me. Your request for amendment must be in writing and must provide a reason supporting your request.

Right to an Accounting of Disclosures. You have the right to request and receive a list of the disclosures that I have made of your health information. Your request must be made in writing.

Tele-Health Only
PO Box 711442
Herndon, VA 20171
www.malekawalters.com
703-474-7410

Your request must state a time period for the disclosures, which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions. You have the right to request that disclosure of confidential information be limited. If I am unable to agree to that restriction, we can discuss other options, such as a referral to another counselor.

Right to Limit Reception on Confidential Information. For example, you may request that I only contact you at a certain telephone number or address. You do not have to give a reason for your request.

Other uses and disclosures of Protected Health Information and any disclosure of Psychotherapy Notes will be made only with your written authorization. After such authorization is given, you may revoke that authorization at any time.

This notice may be amended as needed to comply with federal, state, and professional requirements.

If you believe your privacy rights have been violated, please let me know either in writing or by talking to me. Such a complaint will not result in any retaliation by me. You may also file a complaint with the Secretary of the U.S Department of Health and Human Services.

_____ _____

Signature of Client **Date**

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