Relationships in Balance

Using the principles of psychology to foster balanced relationships.

Philip I. Neal, M.S. LPC-MHSP

Confidentiality Statement

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

I MY PLEADGE REGARDING YOUR MEDICAL INFORMATION

The privacy of your medical information is important to me. I understand that your medical information is personal and I am committed to protecting it. I create a record of the care and services you receive from me. This record may include but is not limited to session notes, assessment tools, information submitted by third parties and records from previous services received. I need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways I may use and share medical information about you. I also describe your rights and certain duties I have regarding the use and disclosure of medical information.

II MY LEGAL DUTY

A. Legal requirements
    1. I will give you a copy of this notice describing my legal duties, privacy practices, and your rights regarding your medical information.
    2. Your medical information must be kept private.
    3. I will follow the terms of the notice that is now in effect.
    4. If my privacy practice terms are changed, I will notify you in writing and draw up a new agreement.

B. My legal rights
    1. I have the right to change my privacy practices and the terms of this notice at any time, if law permits the changes.
    2. I have the right to make changes in my privacy practices and the new terms of my notice effective for all medical information that I keep, including previously created information and information received before the changes.

III USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways I may use and disclose medical information. I will not use your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to me at: Relationships in Balance Philip I. Neal, M.S. LPC-MHSP 7302 Jarnigan Road Chattanooga, TN 37421

A. I may receive and use medical information about you to provide you with medical treatment or services. I may disclose medical information about you to doctors and

other professionals taking care of you should such occasion occur during your session with me. I will only disclose information I believe is necessary for your care and specifically in preventing physical harm to yourself or others.

B. In addition to using and disclosing your medical information for treatment, I may use and disclose medical information for the following purposes:
    1. I retain the right to disclose medical information in response to a court order, subpoena, or other lawful process, under certain circumstances. Under limited circumstances such as a court order, warrant, or grand jury subpoena, I retain the right to share your medical information with law enforcement officials. I may share limited information with a law enforcement official concerning the information of a suspect, fugitive, material witness, crime victim, or missing person when I believe there is eminent danger of physical harm.
    2. I may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

IV YOUR INDIVIDUAL RIGHTS

A. You have the right to look at or obtain copies of your medical information. You must make your request in writing. You may be charged a fee of up to $10.00 for copies of your records in cases where records are relatively large. Additional mailing fees will be charged if applicable.
B. You have the right to be notified when it is necessary to share your information for any reason.
C. You have the right to make a written request that I change information in your record I have provided.
D. You have the right to file a complaint with me if you feel your rights have been violated. The complaint must be submitted in writing to the address given above, or you may file a complaint with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT

By signing this document, I confirm I have read the Confidentiality Statement and will retain a copy for my records:

_____ _____
Client Date

_____ _____
Client Date

I the client authorize the release of my information by my therapist to:

_____, signed on this day: _____.
(professional receiving information) Date