Mary Pat Kelly, Ph.D.
Clinical Psychologist
Lic. PSY 12662

380 Glenneyre • Suite D • Laguna Beach, CA 92651 • (949) 494-0093

NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

My patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultations and correspondence are reviewed by me prior to being filed in the medical records. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information. My practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

To provide treatment: We will use your health information within my office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between doctors, and business office staff. In addition, we may share your health information with referring physicians, specialists, clinical laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to authorized health care providers treating patients even when the provider requesting the results did not originally order the tests.

To obtain payment: We may include your health information with an invoice used to collect payment for treatment you received in my office. We may do this with insurance forms sent to you in the mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.

To conduct health care operations: Your health information may be used during performance evaluations of my staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

Communications: Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact me to make an appointment. These communications may include postcards, letters, and telephone reminders. I may share your health information with those you tell us will be helping you with any auxiliary treatments, medications, or payment. You can request that my practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.

Required by law: We may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Workers' Compensation and similar programs.

You are entitled to receive a copy of the Notice of Privacy Practices

I,_____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and health care operations and laboratory testing.

Signature:_____ **Date:**_____

(parent/guardian if patient is a minor)

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Acknowledgment of Receipt of Notice of Privacy Practices

As of April 14, 2003, medical and mental health practitioners are required by law to provide their patients with a Notice of Privacy Practices, reflecting new federal regulations relating to Personal Health Information (PHI). You do not have to read this Notice, you only need to acknowledge that it was given to you. Even before these new federal laws went into effect, I can assure you that I and other psychologists have been dedicated to protecting the privacy of their clients and the confidentiality of psychotherapy information and records.

I acknowledge that I have received a copy of the Notice of Privacy Practices provided by this office.

Signature:_____ Date:_____