Dianne Brown M.A., LMHC

Notice of Policies and Practices to Protect the Privacy of Your Health Information

This Notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

I. Uses and Disclosures for Treatment and Health Care Operations

I may use or disclose your Protected Health Information (PHI) for treatment purposes with your consent. To help clarify these terms, here are some definitions:

- "PHT" refers to information in your health record that could identify you.
- "Treatment" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider.
- "Use" applies only to activities within my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purpose outside of treatment when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes I have made about our conversation during a private, group, joint or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that I have relied on that authorization.

III. Uses and disclosures with neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have reasonable cause, on the basis of my professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity, I am required by law to report this to the ACS.

Adult and Domestic Abuse: If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

Judicial or Administrative Proceedings:

If you are involved in a court proceeding and a request is made about the professional services, I provided you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious threat to Health or Safety: If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat. I must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

DIANNE BROWN M.A., LMHC

P.O. Box 682214
Orlando, Florida 32868

407-476-8955

Acknowledgement of Receipt of Privacy Practices

This certifies that I have received from my therapist Dianne Brown, a copy of the Notice of Policies and Practices to Protect the Privacy of my Health Information, effective _____ 2021.

_____ _____

Printed name of Client **Date**

_____

Address of Client

_____

_____ _____

Signature of Client **Date**

Print Name of Witness _____

_____ _____

Signature of Witness **Date**

_____ _____

Signature of Parent or Legal Guardian **Relationship to Client**
(If client is under 18)

Dianne Brown, M.A. LMHC
Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

I appreciate your help in keeping the office schedule running timely and efficiently.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

P.O. Box 682214 Orlando, FL 32868 * 407-476-8955 * www.diannebrown.live