Barbara Lauer, LCSW

Confidentiality & HIPAA Privacy Notice

Your personal information, records, and treatment are Protected Health Information (PHI). We are required by law to notify you of the following:

EXCEPTIONS TO PRIVACY & CONFIDENTIALITY

Information may be shared in the following circumstances:

- Healthcare information is shared with insurance companies and vendors for billing, authorization, treatment, and record keeping.
- Office staff has access to some PHI, but only when relevant to their job.
- Providers share limited information when consulting on patient treatment.
- If you sign a Release of Information form requesting specific information be released to a designated individual or organization, especially for coordination of your medical care and services.
- If there is a court order to release your records to legal authorities.
- Mandated Reporting — If there is a clear possibility of harm to you or someone you have discussed, specifically in cases of suicidal or homicidal threats, abuse or neglect of a child or vulnerable adult, or specific infectious and communicable diseases. You will be informed and involved if a mandated report is required.

YOUR RIGHTS

You have a right to your own information and can revoke authorization to release your records:

1. You have a right to decide how we contact you.
2. You have a right to review your file.
3. You have a right to amend your file and submit a written request for corrections.
4. You have a right to a copy of this notice.
5. You have a right to request a list of where your records have been sent.
6. You have a right to revoke past authorizations that you have signed.

QUESTIONS & COMPLAINTS

If you have questions regarding this Privacy Notice or feel your privacy rights have been violated, please contact Barbara Lauer at 1829 NE Alberta St., Suite #5, Portland OR 97211.

You may also file a complaint with: Secretary of the Department of Health and Human Services; Hubert H. Humphrey Bldg.; 200 Independence Ave. SW; Washington D.C. 20201

ACKNOWLEDGEMENT

Please complete and return this form to your provider.

Signature

Date

Printed Name

By signing above, you acknowledge receipt of this HIPAA Privacy Notice.