ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of Liz Cohen, JD, LCSW Notice of Privacy Practices.

_____
(Signature)

_____
(Date)

For Office Use Only

I attempted to obtain written acknowledgement of receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)

_____
_____
_____

NOTICE OF PRIVACY PRACTICES
FOR LIZ COHEN, JD, LCSW

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO ME.

MY LEGAL DUTY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 13, 2003, and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information I created or received before I made the changes. Before I make a significant change in my privacy practices, I will change this Notice and make the new Notice available to you.
You may request a copy of my Notice at any time. For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

I use and disclose health information about you for treatment and payment.

Treatment: I may use or disclose your health information to a physician or other healthcare provider (either using your name after gaining your written permission or without identifying your name) providing treatment to you or for the management of healthcare and related services. This also includes but is not limited to consultations and referrals between one or more providers. For example, to facilitate your access to mental health treatment, I might call a physician to see if s/he is available for an appointment for patients having specific kinds of problems, or if s/he is on your healthcare insurance plan.

Payment: I may use and disclose your health information to obtain payment for services provided to you. For example, I may contact your insurance/managed care provider to obtain information concerning billing for services, copay information, for prior approval/authorization of planned treatment, diagnoses for which they may or may not provide coverage, etc.

Healthcare Operations: I may use and disclose your health information in connection with managed or other healthcare operations. This may include obtaining permission/authorization for therapy visits, making appointments, reviewing quality care, or training supervisees and students, the latter without your name.

Your Authorization: In addition to my use of your health information for treatment and payment, you may give me written authorization to use your health information or to disclose it to a given individual(s) or entity for any purpose (for example, your child's teachers or counselor at school). If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: I must disclose your health information to you, as described in the Client Rights section of this Notice. With your written permission, I may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved in Care: I may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: I will not use your health information for marketing communications without your written authorization.

Required by Law: I must use or disclose your health information when I am required to do so by law. This would include situations where I have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Abuse or Neglect: I must disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim or perpetrator of child and/or elder abuse or neglect; domestic violence; or the possible victim or perpetrator of other crimes. I must disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. For example, if I believe you are a danger to yourself or others, and are unable to take care of/control yourself, I must notify the authorities.

National Security: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. I may disclose to a correctional institution or a law enforcement official having lawful custody of protected health information of inmate or client under certain circumstances.

Appointment Reminders: I may use or disclose your health information to provide you with appointment reminders (such as voicemail messages).

CLIENT RIGHTS

Access: You have the right to inspect or obtain copies of your health information, with limited exceptions, for example, if I think the records may harm you. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. I will charge you a reasonable cost-based fee for expenses such as copies and my time. You may also request access by sending me a letter to the address at the end of this Notice. If you request copies, I will charge you $1.00 for each page to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, I will charge a cost-based fee for providing your health information in that format. If you prefer, I will prepare a summary or an explanation of your health information for a fee. Contact me using the information listed at the end of this Notice for a full explanation of my fee structure.) If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Restriction: You have the right to request that I place additional restrictions on my use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that I communicate with you about your health information by alternative means or to alternative locations**. (You must make your request in writing).** Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that I amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) I may deny your request under certain circumstances. I have 60 days after the request is made to act on the request. A single 30-day extension is permissible if I am unable to comply by the deadline. If the request is denied in whole or in part, I will provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your Protected Health Information (PHI).

Electronic Notice: If you receive this Notice by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about my privacy practices or have questions or concerns, please contact me.

If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. I will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

I support your right to the privacy of your health information. I will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

Contact Information for Liz Cohen, LCSW

9501 Capital of Texas Highway
Suite 105
Austin, TX 78750

(512) 217-2873 (Liz Cohen)