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Confidentiality of Personal and Health Information (PHI)

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

As a Clinical Social Worker licensed by the State of California to provide psychotherapeutic counseling, I am committed to protecting the personal and health information (PHI) of my clients in each of the settings in which such information is received or disclosed.

When you complete an application for health coverage, your signature authorizes your health plan organization to collect personal information about you such as your social security number, date of birth, address, telephone number, etc. As a member of your health plan organization's program, this general consent allows your health plan organization to communicate with me as your authorized provider about treatment and payment decisions.

Health plan organizations typically participate in quality measurement activities that may require them to access your PHI. They are required to have policies to protect this information from inappropriate disclosure and release this information only if aggregated or encoded.

I will not disclose, sell, or otherwise use your PHI unless permitted by law for protection of personal safety and the extent necessary to coordinate your benefit.

I will obtain written authorization from you to use your PHI for any other purpose than indicated above. Any client unable to give consent may designate a legally authorized representative to give consent on his or her behalf.

I will not release your PHI to your employer without your specific authorization, unless law requires such release.

With a minimum of one week (seven days) notice, you may inspect your records, and when needed, you may request a written statement for your own purposes. You also have the right to request an accounting of disclosures of your PHI made for purposes other than those stated above. To exercise any of these rights, you may contact me and/or your health plan organization's Quality Assurance Coordinator. If at any time you have a complaint regarding how your PHI was used and/or disclosed, you may contact me/or your health plan organization and file a grievance. This will be investigated and the outcome reported to you in writing.

**By signing, I confirm that I have read & received a copy of the above statement.*

Signature: ____

Printed Name: ____

Date Received: __________________________