NOTICE OF PRIVACY PRACTICES
Effective Date: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
PLEASE READ IT CAREFULLY.

Uses and Disclosures:
Treatment: Mental health providers do not disclose information to other health care professionals without your written consent.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, services provided, and the medical condition being treated. Should your account become delinquent, your information may be used to seek payment through a collection agency.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of this mental health practice. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your mental health information may be disclosed to law enforcement when a legitimate subpoena or court order is presented. Further, information regarding physical, sexual or emotional abuse of a child or an elderly person, and potentially imminent suicidal and/or homicidal behavior, may be released to law enforcement without your knowledge.

Public Health Reporting: Mental health professionals do not participate in public health reporting.

Licensing Boards: Revelation that another mental health provider has engaged in a sexual relationship with a client must be reported to the licensing board for that provider. The client involved may remain anonymous in such a report.

Additional Uses of Information: Mental health professionals in this office do not mail Appointment reminders. Your health information will not be used to provide you with information about treatments through the mail, and will not be used for fund raising activities.

Other uses and disclosures require your authorization:
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights: You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information
4. The right to amend or submit corrections to your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office manager or your mental health provider.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Caroline B. Williams
1008 Paseo del Pueblo Sur, #270
Taos, NM 87571

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The name and address of the person you can contact for further information concerning our privacy practice is:

Dr. Caroline B. Williams
1008 Paseo del Pueblo Sur, #270
Taos, NM 87571

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMTION

Use and Disclosure of Your Protected Health Information:

Your protected health information will be used by your treatment provider or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices:

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information:

You may request a restriction on the use or disclosure of your protected health information. Your provider may or may not agree to restrict the use or disclosure of your protected health information. If your provider agrees to your request, the restriction will be binding on the practice. Use and disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent:

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of is received will not be affected.

Reservation of Right to Change Privacy Practices:

Your provider reserves the right to modify the privacy practice outlined in this notice.

I have received a copy of the privacy guidelines for private health information as they are applied to Dr. Williams' practice. I have reviewed this consent form and give my permission to Dr. Williams to use and disclose my health information in accordance with the guidelines in this form and the offices general privacy policies.

______________________________________ ______________________

Printed Name Date of Birth

______________________________________ ______________________

Signature Date of Signature

If the client is a minor: I am the legal guardian/custodial parent of _______________________________and I have reviewed this consent form. I give my permission to Dr. Williams to use and disclose my child's health information in accordance with the guidelines in this form and the office's general privacy policies for protected health information.

______________________________________ ______________________

Printed Name Date of Birth

______________________________________ ______________________

Signature Date of Signature