# Confidentiality Agreement

J S Krause Consulting

I. Confidentiality

I will disclose no identifying information about you or the fact that you are my Client without your expressed written consent. Health care providers are legally allowed to use or disclose records or information for treatment, payment and health care operations purposes. I do not routinely disclose information in these circumstances, and as such I will require your permission in advance through your consent at the onset of our professional relationship (by signing the general consent form release of information to third parties) or through your written authorization at the time the need for disclosure arises. You may revoke your permission at any time by contacting me in writing.

II. "Limits of Confidentiality"

There are some important exceptions to the rule of confidentiality as detailed above. These limits will be discussed during the initial session and can be readdressed at any time during our professional relationship upon your request. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits.

I may use or disclose records or other information about you without your consent or authorization in certain circumstances, either by policy or because legally required. The description of circumstances of which disclosure is required is clearly defined by Florida Law and listed below:

*491.0147 Confidentiality and privileged communications. —*

*Any communication between any person licensed or certified under this chapter and her or his patient or client shall be confidential. This secrecy may be waived under the following conditions:*

* (1)When the person licensed or certified under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to that action.*

* (2)When the Client or client agrees to the waiver, in writing, or, when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.*

* (3)When in the clinical judgment of the person licensed or certified under this chapter, there is a clear and immediate probability of physical harm to the Client or client, to other individuals, or to society and the person licensed or certified under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities. There shall be no liability on the part of, and no cause of action of any nature shall arise against, a person licensed or certified under this chapter for the disclosure of otherwise confidential communications under this subsection.*

*History.—ss. 15, 19, ch. 87-252; ss. 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 515, ch. 97-103; s. 1, ch. 2009-103*

III. Client's Rights and Provider's Duties:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information (PHI) about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose.

However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: (1) what information you want to limit; (2) whether you want to limit my use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. [For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voicemail messages.] To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Agreement). On your written request, I will discuss with you the details of the accounting process

Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding.

Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request to amend. I may deny your request if you ask me to amend information that: (1) was not created by me; I will add your request to the information record; (2) is not part of the medical information kept by me; (3) is not part of the information which you would be permitted to inspect and copy.

Right to a Copy of This Notice – You have the right to a paper copy of this notice. You may request a paper copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for confidential clinical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you and I will have copies of the current notice available on request.

Complaints – If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the Florida Department of Health and/or the U.S. Department of Health and Human Services.

IV. Client's Acknowledgement of Receipt of Confidentiality Agreement

Upon signing this document, the aforementioned terms go into effect. We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

_____ _____
Name of Client or Legal Representative (Printed) Date

_____ _____
Signature of Client or Legal Representative Date