John B. Rowe, Ph.D., P.C., LMFT 4108 Park Road, Suite 310 Charlotte, NC 28209

# Notice of Privacy Practices

This notice tells you how I make use of your health information, how I might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything you might not understand. The privacy of your health information is very important to me and I want to do everything possible to protect that privacy.

As your psychotherapist, I have a legal responsibility under the laws of the United States and the State of North Carolina to keep your health information private. Part of my responsibility is to give you this notice about my privacy practices. Another part of my responsibility is to follow the practices in this notice. This notice takes effect on August 01, 2014, and will be in effect until I replace it. I have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in my privacy practices will affect how I protect the privacy of your health information. This includes health information I will receive about you or that I create during the course of your treatment. These changes could also affect how I protect the privacy of any of your health information I had before the changes. When I make any of these changes, I will also change this notice and give you a copy of the new notice. If you have any questions or concerns about the material in this document, please ask me for assistance which I will provide at no charge to you.

Here are some examples of how I use and disclose information about your health information.

I may use or disclose your health information:
1. To any person required by federal, state, or local laws to have lawful access to your treatment program.
2. To receive payment from a third party payer for services I provide for you.
3. If patient is a minor, parents or legal guardians of non-emancipated minors have a legal right to access patient information.
4. To anyone for whom you give written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only affect your health information from that point on.
5. A person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, I will give you an opportunity to object. If you object, or are not present, or incapable of responding, I may use my professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, I will only use or disclose the aspects of your health information that are necessary to respond to the emergency.
6. There are some situations in which I am legally required to take action to protect others from harm even though that requires revealing some information about a patient's treatment. If I believe that a child, elderly person, or disabled person is being abused I must file a report with the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another I am required to take protective actions which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a patient threatens to harm her/himself I may be required to seek hospitalization for the patient, or to contact family members or others who can help provide protection.

I will not use your health information for any marketing, development, public relations, or related activities without your written authorization. I cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission. As a patient of this psychotherapy practice, **you have these important rights:**
A. I am required to keep appropriate records of your treatment. Because these records contain information which can

***Continued on next page***

be misinterpreted by someone who is not a mental health professional, it is my general policy that patients may not review them. However, if you request, I will provide you with a treatment summary unless I believe that to do so would be emotionally damaging. If that is the case, I will be happy to forward the summary to another appropriate mental health professional who is working with you.

B. You can make a written request to have me communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this office, and I am treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.

C. You can make written request that I place other restrictions on the ways I use or disclose your health information. I may deny any or all of your requested restrictions. If I agree to these restrictions, I will abide by them in all situations except those which, in my professional judgment, constitute an emergency.

D. I do not disclose your health information for purposes other than treatment, payment, or as court ordered. This can go back as far as six years, but not before August 01, 2014.

E. If you believe I have violated any of your privacy rights, or you disagree with a decision I have made about any of your rights in this notice, or if you have any questions, please speak with me, John B. Rowe, in person. Alternatively, you may submit a written complaint to me at: John B. Rowe, Ph.D., P.C., LMFT, 4108 Park Road, Suite 310, Charlotte, NC 28209-2261. I take protecting your privacy very seriously and will work with you to find an appropriate resolution.

F. You may also submit a written complaint to the United States Department of Health and Human Services or to the North Carolina Board of Licensed Professional Counselors. I will provide you with those addresses upon written request.

By signing this document I am acknowledging that I have been informed about how my privacy and confidentiality will be maintained by John B. Rowe, Ph.D., P.C., LMFT. I understand that I may request a copy of this form for my records.

Signature _____ Date _____