HIPAA

Client Notice of Confidentiality

State and Federal law and regulations protect the confidentiality of patient records maintained by Daylily Health. Generally, the counselor:

1. May not say to a person outside the counseling office that a client attends counseling session.
2. Disclose any information identifying a client as a recipient of services.

However, the following events allows for disclosure of patient information and records:

1. The client consents in writing.
2. The disclosure is court ordered.
3. The disclosure is made to medical personnel in a medical emergency.
4. The disclosure is made to qualified personnel for research, audit, or counseling evaluation **(note: the use of county grant or third-party payer allows access to the diagnosis and the case record to validate payment by the county or third-party payer)**
5. The client has verbally stated thoughts of suicide or homicide with intent to act
6. The counselor is made aware of abuse.

State and Federal law and regulations do not protect information about suspected child abuse, neglect, or adult abuse from being reported under State law to appropriate State or local authorities. It is the clinician's duty to warn any potential victim when a significant threat of harm has been made. Regardless of the method of contact utilized, Daylily Health shall protect the confidentiality of the client.

I give my permission to allow mailing from Daylily Health to display their company name in the return address of an envelope addressed to my home: _____ (initial)

I do not give my permission to receive mailings addressed from Daylily Health to my home: _____ (initial)

Violation of the Federal law and regulation by a clinician is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. **I have read, understand, and agree to these policies.**

_____ _____

Print Name of Client or Parent/ Guardian **Date**

_____ _____ _____

Client or Parent or Guardian Signature **Witness** **Date/Time**