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PRIVACY &CONFIDENTIALITY IN THERAPY, TESTING & CONSULTATION

Federal and state laws regulate privacy within the therapy relationship. The following guidelines govern when Protected Health Information (PHI) can be released ***without*** your consent or authorization and when your consent and authorization ***are needed***. These guidelines apply to the following Protected Health Information (PHI):

- Dates of Service
- Session Start & Stop Times
- Summary of Diagnosis
- Functional Status
- Type of Treatment (CPT code)
- Treatment Plan
- Results
- Symptoms
- Prognosis
- Progress to Date

R**ight to Inspect and Copy:** In most cases, you can have legal access to Protected Health Information (PHI) upon request, including the right to inspect and copy your medical and billing records. To do this you must submit your request ***in writing***. I may charge a fee for the costs of copying and mailing. Virginia law explicitly excludes "psychotherapy notes" from disclosure, defined as notes documenting or analyzing the contents of conversations during counseling or therapy. Psychotherapy notes are ***not*** protected, however, from subpoena.

I may deny your request to inspect and copy your record or to access information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative proceeding. Should I not allow you to inspect and/or copy your Protected Health Information, a written statement will be placed in your record stating that in my professional judgment, the furnishing to or review by the patient of this health records would be:

- reasonably likely to endanger the life or physical safety of the individual or another person, OR
- that such health record makes reference to a person other than a health care provider & the access requested would be reasonably likely to cause substantial harm to such referenced person.

Right to Amend: If, after inspecting your record, you feel that information I have about you is incorrect or incomplete, you may ask that it be amended. Your request must be made to me in writing and must include the reasons supporting your request. I may deny your request if you ask me to amend information that:

- was not created by me, although I will add your requested information to the record
- is not part of the medical information kept by me
- is not part of the information which you would be permitted to inspect and copy
- is already accurate and complete.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Prevent Harm: I am required by law to attempt to prevent harm from occurring if I suspect or become aware of:

- **Child abuse or neglect:** If I have reason to suspect that as child is being abused or neglected sexually, physically, or emotionally, I am required to report the matter immediately to The Virginia Department of Social Services.
- **Adult abuse, neglect, or exploitation:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected, exploited, or the victim of domestic violence, I am required to provide relevant information and report the matter to the Virginia Department of Welfare or Social Services.
- **Suicidality:** If I become aware of any credible intent to take one's own life, I will disclose information as needed to prevent self-harm.
- **Homicidality:** If I become aware of a specific and immediate threat to cause serious bodily injury or to take the life of another person, I will disclose information to keep that person safe.
- **Health oversight:** I will report misconduct by other professionals, whether in health care or in other professions. If you are a health care provider, I must report your treatment if I believe that your condition places the public at risk.

In these instances, I am required to release information to child protective service workers; The Department of Social Services and/or Department of Welfare; court-appointed advocates; law enforcement officers; or evaluators for involuntary commitment. I may also be required to warn a potential victim and/or their parent or guardian (if under age 18), and/or to seek your hospitalization. Your permission for these disclosures is not required.

Court Proceedings:

- **Subpoenas:** I must provide your records when requested by a valid subpoena. I may be required to provide records under seal until their release (or return to me) is determined by a judge. I will make every effort to inform you if your records are requested by subpoena, but I cannot always prevent their release.
- **Civil Court:** In civil court cases, therapy records are not privileged when child abuse is suspected, when a patient's mental health is an issue, or when a judge deems the information "necessary for the proper administration of justice."

- **Criminal Court:** In cases of criminal activity, therapist-patient privilege is not protected by law in Virginia, although records can sometimes be protected on another basis.
- **Child Custody:** In Virginia, the therapy records of parents ***may not*** be used as evidence in child custody cases, but a child's records do not have the same protection.
- **Evaluations:** If I do an evaluation for a third party or under court order, privacy is not protected.

Emergencies: If there is an emergency and I cannot ask your permission about disclosure, I am allowed to share information if I believe you would have wanted me to do so or if I believe it will be helpful to you.

Worker's Compensation Claims: For Worker's Compensation Claims, I am required, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Health Insurance: Your signature on the Financial Agreement allows me to release to your insurance carrier the Protected Health Information (PHI) listed above so that you can obtain insurance coverage. Any insurance request for personal health information not listed above will require a separate written and signed Authorization from you.

Records of Minors: Although minors can request treatment without parental consent, they may not deny the access of parents to their mental health records, regardless of the parent's custody status. Minors can grant, or refuse to grant, disclosure to other parties. I can refuse to disclose a minor's records to parents if I believe that disclosure would result in harm to the minor.

Authorization to Release Information: If you wish me to contact or provide information to another individual or institution, you will be asked to sign an Authorization to Release Information, which specifies what information will be shared, with whom, for what purpose, as well as a date, event, or condition upon which it expires. You may ask to restrict the Authorization by information disclosed, the use made of the disclosure, and/or the person or person to whom these limits apply. You may revoke an Authorization in writing at any time. No Authorization is needed for the situations described above.

Peer Review: HIPAA permits this disclosure of information about a patient for consultative purposes, as it is considered part of treatment. By signing at the bottom, you acknowledge your awareness or this practice and give permission for it. Please let me know if you do not want this to take place and your request will be honored.

Internet and Social Media: I do not accept friend or contact requests from current or former patients on any social network site (e.g., Facebook or LinkedIn). I do not search for patients or their family members on the Web. You may find my practice listed on business rating sites (e.g. Yelp or Healthgrades), although I have not initiated these listings and make no request for ratings or testimonials. I do not communicate by email, which is not a private and/or confidential method of communication.

Changes to Policies and This Notice: I reserve the right to change these policies and/or this notice. Changes will apply to medical information I already have about you as well as any information I receive in the future.

I have read and understood the above information about confidentiality and its limits. I have been provided with a copy of Dr. Velkoff's privacy practices and I consent to these policies as a condition of receiving services.

_____	_____	_____
Print Name	Patient Signature	Date

_____	_____
Parent or Guardian Signature, if applicable	Date

Please retain one copy for your records.