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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My commitment to your privacy:

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private (HIPAA). These laws are complicated, but I must give you this important information. Please ask me if you have any questions or problems.

How your protected health information is used and disclosed with your consent:

I use the information I obtain from you to provide you with **treatment** and to arrange **payment** for services. After you have read this notice, you are asked to sign a **consent form** to let me use your information in these ways. If you do not consent and sign this form, I cannot treat you. For any other use of your information, I will first discuss it with you and ask you to sign a form to authorize this release.

Disclosing your health information without your consent:

There are times when laws require me to share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. I will share information with persons who are able to help prevent or reduce the threat.
2. If you reveal to me that you have been physically or sexually abused or assaulted by someone, I am required by law to report this to Child or Adult Protective Services. I will discuss this with you at that time.
3. When I am required to do so by legal or court proceedings.
4. For Workers' Compensation, Social Security, or other benefit programs.

Your rights regarding your health information:

1. You can ask me to communicate with you in the way you feel is most private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.
2. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it.
3. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing, stating the reasons you want to make the changes.
4. You have the right to a copy of this notice.
5. You have the right to file a complaint if you believe your privacy rights have been violated. All complaints must be in writing. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you if they arise. If you have any questions regarding this notice or my health information privacy policies, please let me know.

My signature below confirms that I have read, understand, and agree to these privacy practices.

Patient or Guardian

Date