

Cynthia Benedict Goering, MA, LMHCA

6817 Greenwood Ave N

Seattle, WA 98103

206.229.9114

<http://www.cynthiagoering.com>

WA State Mental Health Counselor Associate License: MC60140954

Notice of Privacy Practices

This document describes how your medical record and health information may be used and disclosed, and how you can access this information.

The law protects the privacy of information we create and obtain in providing health care and services to you, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). Your protected health information includes your diagnoses, treatment, information from other providers, and billing payment information relating to these services. Federal and state laws allow me to use and disclose protected health information for payment purposes. I understand that our personal health information is very sensitive. I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so. Domestic Violence Treatment Laws do require me to give some specific information to victims and authorities.

You Health Information Rights

The health care and billing records I create and store are the property of Cynthia Benedict Goering. The protected health information in it belongs to you. You have a right to:

- Receive, read, and ask questions about this document.
- Ask me to restrict certain uses and disclosures. You must deliver this request in writing to me.
- Request and receive from me a paper copy of the most current Notice of Privacy Practices.
- Request that you be allowed to see and get a copy of your records.
- Have me review a denial of access to your records.
- Ask me to change something in your records. Please give me this request in writing. If your request is denied, you may write a statement of disagreement. It will be stored in your medical record and included with any release of your records.
- Request a list of disclosures of your records without charge every 12 months. Requests made more frequently will require a fee to process. Please sign, date, and give me your request in writing. The list may not include disclosures for treatment, payment or health care operations.
- Ask that your records be given to you by another means or at another location.
- Cancel prior authorizations to use or disclose health information by giving me a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before I have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain payment.

I have been informed of my mental health care provider's *Notice of Privacy Practices*.

Client's Signature	Date	Parent/Guardian's Signature (if applicable)	Date
--------------------	------	---	------

Therapist's Signature	Date
-----------------------	------

Minors also covered by this acknowledgement:
