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CONFIDENTIALITY INFORMATION FORM

As with other health care professional, the personal health information gathered at WCFV is protected by the Health Insurance Portability and Accountability Act (HIPAA), as well as other federal and state laws. It is the policy of WCFC to protect, to the best of our ability, your confidentiality. This means that no information is released to anyone or to any organization without a client's written consent.

Limits of Confidentiality: There are some exceptions to confidentiality required by state law, federal law and HIPAA. A therapist may be required to release information if:

1. The client presents a danger to themselves.
2. The client presents a danger to others.
3. Child or elder abuse and/or neglect is suspected.
4. The client's mental condition becomes an issue in a lawsuit.
5. The client authorizes a release of information with a signature.
6. For other government, peer review or regulatory practices.

Consent to Use/Disclose Personal Health Information: In accordance with HIPAA, we are required to give you a written description of your rights under HIPAA and record that you have received a copy of the Notice of Privacy Practices. A copy of the practices will also be posted in the reception area. If any changes/revisions are made, clients will receive the updated version. Also, we are required to obtain written consent to use and disclose your personal health information in planning, treatment, and health care operations undertaken by your practitioner. The following is a summary of the uses. Disclosures of your personal health care information and your rights.

WVFC the practitioner, may use and/or disclose written/ oral/electronic health information about the client that is created or received by the practitioner that may include information about the client's family history, health status, symptoms, evaluations, assessments, diagnosis, treatments, procedures, prescriptions and other similar types of health related information.

WVFC will only disclose personal health information to persons or organizations who are also covered by the confidentiality practices of HIPAA or are under contractual confidentiality agreements. WVFC will not release material to persons or organizations that will not protect your confidentiality without your authorization or prior knowledge.

WVFC the practitioner may use and disclose the information in order to:

1. Make decisions about, and plan for your care and treatment.
2. Refer to, consult with, coordinate among and manage along with other health care providers for your care and treatment.
3. Determine your eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of your health care.
4. Perform various office, administrative and business functions that support your practitioner's efforts to provide you with, arrange for and be reimbursed for quality cost effective health care.

The client has the right:

1. To receive and review a written description of how WVFC/ the practitioner will handle your health care information.
2. To ask that certain information be restricted from release. This request needs to be in writing and discussed with your practitioner. The practitioner is not required by law to agree to such requests, however.
3. To receive an annual report of information disclosures made by WVFC or the practitioner.
4. To review the personal health information collected by the practitioner, except if it is deemed not in the client's best interest.
5. To amend information in the practitioner's file through a written request.

By signing below, I agree that I have received the Notice of Privacy Practices and have reviewed the above information. I give consent to WVFC/my practitioner to use and disclose personal health information for the planning, treatment and health care operations involved in my care and payment for my care.

_____ _____

Client Signature Date

(If you are here with a child we need the following two signatures)

_____ _____

Signature (Mother) Date

_____ _____

Signature (Father) Date

If you have concerns about your privacy you may contact WVFC privacy officer, your insurance company or your psychologist.

Revised 12-12-03