**CORNERSTONE COUNSELING, BRANDON DIXON LLC**

 **2909 Bent Avenue, Unit B1**

**Cheyenne, Wyoming 82001**

**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. I am also required by the law to do this. Disclosure law is complicated, but I must provide you with important information. I cannot cover all possible situations, so please seek specific legal advice about any questions or problems concerning your legal rights as relates to your treatment services.

I will use information about your health, which I obtain from you or from others primarily for the purpose of providing you with treatment; to arrange payment for my services, including the use of collection agencies; or for some other business activities, which are called in the law, health care operations. After you have read this notice please sign my Informed Consent for Treatment form to let me use and share your information. If you do not consent and sign this form, I cannot provide treatment services for you.

If you or I want to use or disclose (receive, send, share, release) your information for your ongoing treatment, or for another purpose you wish, we will discuss this and you’ll be asked to sign a RELEASE of INFORMATION Form (ROI) indicating the specific nature of the request and the involved parties.

Of course I will keep your health information private, but there are some times when the laws require me to use or share it such as:

1. When there is serious threat to your health and safety or the health and safety of another individual or the public - I will only share information with a person or organization able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires me to do so.
4. For Workers’ Compensation and similar benefit programs.

There are some other situations like these but which do not happen very often.

# YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. If I agree, I cannot change the agreement without your authorization.
2. You have the right to ask me to limit what I tell certain individuals involved in your care or the payment for your care, such as family members and friends.
3. You have the right to request to look at the health information I have about you such as your medical and billing records notes. You also have the right to:

**CONTINUED on page 2**

* Ask for and receive information about a therapist’s qualifications, including licensure, education, training, experience, special areas of practice and limits on practice.
* Written information, before therapy, about fees, methods of payment, insurance coverage, and number of sessions likely needed, substitute therapists (vacations and emergencies), and appointment cancellation.
* Refuse audio or video recording of sessions.
* Refuse to answer any question or give any information you choose not to answer or give.
* Know if your therapist will discuss your case with supervisors, other consultants or students.
* Ask the therapist to inform you of your progress.
1. You have the right to request to amend your records.
2. You have the right to request an accounting of disclosures.
3. You have the right to file a complaint

**REPORT PROBLEMS or VIOLATIONS:**

If you have any problems with any part of your treatment, please feel free to talk with me, Brandon Dixon, LCSW. You may also contact the Wyoming Mental Health Professions Licensing Board at: 2001 Capitol Avenue, Room 104, Cheyenne, Wyoming, 82001, Telephone 307-777-7788.

Print Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Your Name (if different than client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client: self \_\_\_ parent \_\_\_ guardian \_\_\_

**NOTICE OF PRIVACY PRACTICES,** **page 2**