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Licensed Clinical Social Worker Box 2004 • 212 Washington St, Monument, CO 80132

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your treatment generated by this practice and made by ***Karen Wiens, LCSW***.

My Responsibilities

I am required by law to maintain the privacy of your mental health information and provide you a description of my privacy practices. I will abide by the terms of this notice and notify you if cannot agree to a requested restriction. I will accommodate reasonable requests you may have to communicate health information by alternative means or to other healthcare providers.

Use and disclosure of your Medical Information.

Confidentiality

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed psychologist, a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, or a unlicensed psychotherapist practicing under the supervision of a licensed psychotherapist. I may not consult with other experts regarding treatment issues in your case without your written permission. The information provided by you during therapy is legally confidential except as required by law. Exceptions to confidentiality include, "threat of serious harm to self or others, as in the case of child abuse, suicide or grave disability." The exceptions can be found listed in the Colorado Statutes (see Section 12-43-218, C.R.S. [1988], in particular). You should be aware that except in the case of information given to a licensed psychologist, legal confidentiality **does not apply** in a criminal or delinquency proceeding.

Your Medical Information Rights

Client Rights and Important Information

Mental health records are the physical property of the mental health practitioner.

a) You are entitled to receive information from me about my methods of therapy; the techniques I use; the duration of your therapy (if can be determined); and my fee structure. Please ask if you would like to receive this information. .

b) You can seek a second opinion from another therapist or terminate therapy at any time.

c) In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs in any professional therapeutic relationship, it should be reported to the State Grievance Board.

The Colorado Department of Regulatory Agencies:

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice therapy. No one may hold these titles unless he/she has met specific standards set by this Regulatory Agency. The license is a guarantee you are seeing a professional who has been trained and supervised in the diagnosis and treatment of mental conditions.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the State Grievance Board, Room 1340, 1560 Broadway, Denver, Colorado 80202. The State Grievance Board's telephone number is (303) 894-7766.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by contacting the State Grievance Board at the above address and phone number. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to me will be made only with your written permission. If you provide me with permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose medical information about you for the reasons covered by your written authorization. I am required to retain my records of your treatment.

__________________________________ ________________

signature date