ALISON YOUNG
THERAPY

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.
The privacy of your health information is important to me.

My Legal Duty: I am required by applicable federal and state law to maintain the privacy of your health information. I am also required by law to give you this notice about my privacy practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on October 1, 2009, and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my notice effective for all health information that I maintain, including health information I created or received before I made the changes. Before I make a significant change in my privacy practices, I will change this notice and make the new notice available.

You may request a copy of my notice at any time. For more information about my privacy practices, or for additional copies of this notice, please contact me using the information listed at the end of this notice.

Uses and Disclosures of Health Information

I use and disclose health information about you for treatment, payment, and healthcare operations as described below:

Treatment: I may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: I may use or disclose your health information to obtain payment for services I provide to you.

Healthcare Operations: I may use or disclose information about your health in connection with my healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to my use and disclosure of your health information for treatment, payment, or healthcare operations, you may give me written authorization to use your health information or disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: I must disclose your health information to you, as described in the Patients Rights section of this notice. I may disclose information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that I may do so.

Persons Involved in Care: I may use or disclose health information to notify, or assist in the notification (including identifying or location) of a family member, your personal representative or other person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: I will not use your health information for marketing communications without your written authorization.

Required by Law: I may use or disclose your health information when I am required to do so by law as described in your signed confidentiality statement.

Abuse or Neglect: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert serious threat to your health or to the health and safety of others.

National Security: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national securities activities. I may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: I may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that I provide copies in a format other than photocopies. I will use the format that you request unless I cannot practically do so. You must make a request in writing to obtain access to your health information. You may submit your written request to the contact information listed at the end of this notice. I will charge you a reasonable cost-based fee for expenses such as copies and staff time. I will charge $3.50 for each page and $150.00 per hour to generate your health information no matter what format. If you prefer, I will prepare a summary or an explanation of your healthcare information for a similar fee.

Disclosure Accounting: You have a right to receive a list of instances in which I disclosed your healthcare information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before October 1, 2009. I will charge $3.50 for each page and $150.00 per hour to generate the list you requested.

Restriction: You have the right to request that I place additional restrictions on my use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in emergency).

Alternative Communication: You have the right to request that I communicate with you about your health information by alternative means or alternative locations. You must make such a request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. I will communicate with you about your health information by alternative means or to alternative locations if I am able to do so.

Amendment: You have the right to request that I amend your health information. Your request must be in writing and it must explain why the information should be amended. I may deny your request under certain circumstances.

Questions and Complaints

If you want more information about privacy practices or have questions or concerns, please contact as specified below. If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about access to your health information or in response to a request you made to amend or restrict the use and disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. I support your right to privacy of your health information. I will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

Contact: **Alison Young, MFT**
Address: 11500 West Olympic Blvd. Suite 615
Los Angeles, CA 90064
Telephone: (310) 482-1199
Email: alisonyoungtherapy@gmail.com

Please continue reading and sign on page 3

I wish to be contacted in the following manner (Check all that apply):

[] Home Telephone
- [] OK to leave detailed information message
- [] Leave message with call-back number only

[] Written Communication
- [] OK to mail to my home address
- [] OK to mail to work/office address
- [] OK to e-mail

[] Cellular Phone
- [] OK to leave detailed information message
- [] Leave message with call-back number only

[] Work Telephone
- [] OK to leave detailed information message
- [] Leave message with call-back number only

I hereby testify that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it thoroughly. I hereby certify that I have read and understood the Notice of Privacy Practices and that I have received answers to questions regarding my privacy rights.

Printed Name:_____

Signature:_____ Date:_____