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## **Notice of Policies and Practices to Protect the Privacy of Your Health Information**

This notice describes how psychological and medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

### **I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

The following are the ways I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your general consent. PHI refers to information in your health record that can identify you.

*Treatment:* I may use and disclose Health Information to coordinate or manage your health care and other services related to your health care. An example of treatment would be consultation with another health care provider, such as your family physician or a mental health therapist that worked with you previously.

*Payment:* I may use and disclose Health Information so that others or I may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

*Health Care Operations:* I may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of my clients receive quality care and to operate and manage my office. Examples of health care operations are business-related matters such as file management, and case management and care coordination.

### **II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have

relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

### **III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse*: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- *Abuse of the Elderly and Disabled*: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- *Regulatory Oversight*: If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- *Judicial or Administrative Proceedings*: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety*: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- *Worker's Compensation*: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

### **IV. Client's Rights and Our Professional Duties**

You have the following rights regarding Health Information we have about you:

*Right to Inspect and Copy*: You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing to me.

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*Right to Amend:* If you feel that Health Information I have is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for my office. To request an amendment, you must make your request, in writing to me.

*Right to an Accounting of Disclosures:* You have the right to request a list of certain disclosures I made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing to me.

*Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

*Right to Request Confidential Communication:* You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to me. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

*Right to a Paper Copy of This Notice:* You have the right to a paper copy of this notice

#### **IV. My Professional Duties:**

I am required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

If I revise my policies and procedures, I will provide you with the relevant updates.

#### **V. Questions and Complaints**

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact me at address and phone number listed below.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

I understand and accept the aforementioned policies and practices.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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