Health Care Information
Notice of Privacy Practices and Limits of Confidentiality
for

James M. Claiborn Ph.D. ABPP
205 Ocean Ave. Portland ME 04103
7 W Figueroa St. Suite 300
Santa Barara CA 93101
207 799-0408 or 866 205 8728

A federal law known as the HIPAA act requires that people seeking health care services receive a notice of how health care information obtained about you may be used.

In compliance with that law, I am providing this information to you. You will be asked to sign this and return it to me as an acknowledgment that you were provided with the notice. You will be offered a copy for your own records if you desire one. As a psychologist licensed in California, Delaware, Maine, New Hampshire, and New York I practice in accordance with state law, and relevant federal law.

Each time you access health services from me I create a record. This document may contain information about you, including symptoms, diagnosis, test results and my observations of you and your problems. The function of the record is to facilitate my providing care and to provide information to others you may designate to facilitate your access to health care. It also serves as a legal document describing care provided. It may be used to verify to insurance companies or other agencies that services were provided in order to obtain reimbursement. You have the right to restrict certain disclosures of protected health information to a health plan when you pay out of pocket in full for my services

You have the right to request restriction of how your health care information is disclosed with some exceptions. If I come to believe that a child, elderly person or incapacitated adult is being abused I am obligated to report this to the appropriate agency. If I come to believe that a client is threatening serious bodily harm to themselves or others or serious property damage, I am obligated to take protective action including notification of identified victims or appropriate authorities, warn family members or seek civil commitment.

You have a right to request a copy of your health care record.

You have the right to submit a request to amend the record. This request must be made in writing and I reserve the right to refuse to make the amendment. If I refuse, I will provide a written explanation of the reason for refusal.

You have the right to request an accounting of certain disclosures. This does not include disclosures made for treatment, payment or health care operations. The request must be made in writing. The accounting will in include if requested disclosure date, entity that received information, a brief description of the purpose of the disclosure or a copy of the authorization or request or certain summary information concerning multiple disclosure. I will also obtain an authorization from you before using or disclosing protected health information in any way not described in this notice.

You may request confidential communication of your health information including use of specific phone numbers to contact you, or communication of your health information to another provider.

You may revoke your consent to communicate or disclose your health information except to the extent that action has already been taken.

It is my responsibility to maintain privacy of your health information, provide you with legal notice as to my duties and privacy practices with regard to your health information, abide by the terms of this notice, notify you if we are unable to abide by your restriction, and accommodate reasonable requests to communicate your health information. You have the right to be notified (a) if there is a breach (use or disclosure of your protected health information in violation of the HIPPA privacy rule) involving your protected health information, (b) that protected health information has not been encrypted to government standards, and (c) my risk assessment fails to determine that there is a low probability that your protected health information has been compromised.

I reserve the right to change my privacy practices and will notify you of any new provisions that have an effect on your information.

Behavioral health, substance abuse and HIV related health information is subject to special restrictions. No information will be released without your written consent except as detailed in the informed consent.

I have been offered a copy of Health Care Information Notice of Privacy Practices and Limits of Confidentiality for James M. Claiborn Ph.D. ABPP.

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Signature of client/parent or guardian Date

Please direct mail to 7 W. Figueroa St, Suite 300, Santa Barbara, CA 93101

To email your forms, click my email address: **anxietyshrink@gmail.com** and attach your completed forms.

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