Anne E. Croskey, Ph.D.
3021 Bethel Road
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Columbus, Ohio 43220
614-457-5588

NOTICE OF PRIVACY PRACTICES FORM

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. PLEASE READ IT CAREFULLY!

For the most part information that you reveal to me is confidential. There are, however, several exceptions to that statement.

1. I may disclose information NECESSARY to conduct treatment, payment or health care operations. Examples might be: talking with your physician, talking with your insurance company, talking with my billing person, talking with the psychiatrist I consult on various cases, or talking to your referral source.
2. I must report to Franklin County Children Services or to the police if I believe a child is being abused or neglected. Similarly, I must report elder abuse to the police.
3. I cannot honor confidentiality if there is a serious threat to self or others such as suicide, homicide or assault. This kind of threat must be reported to police, emergency services and/or to the person who is the focus of harm.
4. Additional uses and disclosures will be made only after you have signed a written authorization. You may revoke such authorization unless the action has already been taken.
5. You should know that I may contact you by phone to provide treatment reminders, to collect fees, to make referrals and to suggest treatment alternatives. From time to time we may have a telephone appointment. It is possible that someone may overhear this communication.
6. By law I must respond to court-ordered subpoenas.

The following describes your rights with respect to protecting your health information (your psychotherapy record).

1. You may request restrictions on specific uses and disclosures and I must document that I agree to those – assuming the request is viable.
2. You may request reasonable changes in how I communicate with others.
3. You may inspect /copy your protected health information, including psychotherapy notes, for as long as the information is maintained, except for information compiled in anticipation of a civil, criminal, or administrative proceeding. Moreover you may not have access to certain research information.
4. You may amend your record unless the record is deemed accurate and complete.
5. You may have an accounting of any disclosures that I make.
6. You will have a copy of this form for your records.

As your provider, I will:

1. Maintain the privacy of your protect health information.
2. Abide by the terms of this notice.
3. Reserve the right to change the terms of this notice and submit the revised notice to you.

Complaints may be made to the Secretary of Health and Human Services and to me as your Provider and company Privacy Officer. I will respect your complaint and not retaliate if you should complain about privacy rights violations.

Signature (signifies that I have read and agree with the above)_____

Date: _____

Anne E. Croskey, PhD

I, _____, acknowledge receipt of the **Notice of Privacy Practices Form** from Anne E. Croskey, PhD, 3021 Bethel Road, Suite 107, Columbus, Ohio 43220

Signature: _____

Date: _____