



## Wendy Boyer LMFT, LLC

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### NOTICE OF PRIVACY PRACTICES

**This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

I have a duty to maintain privacy of your health information and to provide you with this notice. By signing this notice, you agree that I may use or disclose your Protected Health Information for purposes of diagnosis, treatment, obtaining payment, or to conduct healthcare operations. For example, if you choose to use insurance, to receive payment I must provide information about you to your insurance company.

**Other permitted and required uses and disclosures that may be made without your consent, authorization or opportunity to object:**

**Abuse or Neglect:** If I suspect abuse or neglect of a child or elder, I am mandated to make a report to the appropriate public authorities.

**Danger:** If I suspect you are in imminent danger of harming yourself or someone else, I am mandated to make a report to the person at risk and to the public authorities.

**Legal Proceedings:** I may disclose Protected Health Information in response to a court order or subpoena or in certain other legal proceedings.

**You have the following rights regarding health information I maintain about you:**

**Right to Inspect and Copy:** You have the right to inspect and request copies of information that may be used to make decisions about your care. Usually this includes demographic and billing records but does not include psychotherapy notes. To inspect and/or receive copies of information, you must submit a request in writing. If you request a copy of information, I may charge a fee for the cost of copying, mailing or other supplies associated with your request. I must respond to your request within fifteen days of receipt.

**Right to Amend:** If you feel that health information about you 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 me. Your request for amendment must be in writing and must provide a reason supporting your request.

**Right to an Accounting of Disclosures:** You have the right to request an Accounting of Disclosures I have made of information about you. You must submit your request in writing to the above address. Your request must state a time period for the disclosures, which may not be longer than six years and may not include dates before March 23, 2011.

**Right to Request Restriction on Uses and Disclosures:** You may request that disclosure of confidential information be limited. If I am unable to agree to that restriction, we can discuss other options, such as referral to another counselor.

**Right to Limit Reception of Confidential Information:** For example, you may request that I contact you at a certain telephone number or address. You do not have to give a reason for your request.

**Right to a paper copy of this Notice.**

**Other uses and disclosures of Protected Health Information and any disclosure of Psychotherapy Notes will be made only with your written authorization. After such authorization is given, you may revoke that authorization at any time. This Notice may be amended as needed to comply with federal, state and professional requirements. This notice is effective March 23, 2011.**

If you believe your privacy rights have been violated, please let me know either in writing or by talking with me. Such a complaint will not result in any retaliation by me. You may also file a complaint with the Secretary of the US Department of Health and Human Services.

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Signature of Client / Custodial Parent / Guardian

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Date

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Printed Name of Client