William Douglas McFarland LCSW
6304 Roseborough Drive
Austin, Texas 78747
512/705-1462 cell/office

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this practice's Notice of Privacy Practices, which explains how my PHI will be used and disclosed. I understand that I was presented and/or received a copy of this document.

Client Confidentiality Information and Consent

All information between counselor and client is held strictly confidential unless:

1. The client authorizes a release of information with his or her signature
2. The client presents a physical danger to self
3. The client presents a physical danger to others
4. Child/elder abuse or neglect is suspected
5. The client seeks treatment to avoid detention or apprehension or enable to commit a crime
6. You are under the age of 16 and are a victim of a crime
7. To decide an issue concerning a deed or conveyance, will or other writing executed by you
8. You file a suit against your therapist for breach of duty or your therapist files suit against you
9. You are involved in criminal prosecution
10. You have filed suit against any one and have claimed mental or emotional damages as part of the suit
11. You file a complaint with the licensing board
12. There are fee disputes between the therapist and the client (collections)
13. The court orders release or review of the records
14. Situations which, in the therapist's judgment, it is necessary to warn or disclose for safety
15. You have consented to disclosure by signing a release of information form
16. If you are under the age of 18, your parent and/or legal guardian is entitled to all information about your treatment such as your goals, your progress, the focus of sessions, and treatment recommendations etc. If you do not want specific details disclosed to your parent, your parent must sign a confidentiality waiver form
17. AIDS/HIV infection and possible transmission
18. If a claim is filed with your insurance company for payment or reimbursement of services. In this case, the insurance company has the right to review all records including diagnosis.

In the case of abuse or suspected abuse I am required by law to notify appropriate authorities. If you have any further questions, please discuss them with me. By signing this form, you are giving your consent to the undersigned therapist to share confidential information to any persons mandated by the law and the managed care company responsible for providing and paying for mental health services. You are releasing to hold harmless the undersigned therapist from any departure from your right to confidentiality that may result.

Patient name printed	Date of Birth
Patient signature	Date
Parent or Guardian Signature	Date
Doug McFarland LCSW	Date