HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by me in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information.

I may use and disclose your medical records for each of the following purposes: TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be, with written permission, coordinating your care with another provider. In the case of emergency or potential or likely harm to self or others, permission is not required.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- HEALTH CARE OPERATIONS include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review. Our office may contact you to provide appointment reminders or information about treatment issues, leaving a message if necessary.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your earlier authorization.

YOU HAVE THE FOLLOWING RIGHTS with respect to your protected health information, which you can exercise by presenting a written request to me:

1. The right to request restrictions on certain uses and disclosures of protected health information.
2. The right to reasonable requests to receive confidential communications of protected health information from me by alternative means or at alternative locations. For example, receiving billing and/or telephone calls at an alternate address. You must request this in writing.
3. The right to inspect and receive a copy of your protected health information, unless your provider deems this information harmful to your health. This may be subject to certain limitations and fees. Due to the nature of mental health treatment, any interest in inspecting your record must be discussed with your provider first. Psychotherapy notes and raw test data resulting from psychological test administration are the property of the clinician. These are not part of the medical record and are not available for disclosure.
4. The right to amend your protected health information. You must submit sufficient information to support your request for an amendment. This must be in writing. Any amendment cannot alter the original record.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice from me upon request.

HIPAA NOTICE OF PRIVACY PRACTICES

I am required by law to maintain the privacy of your protected health information and to provide you with the notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of May 1, 2010, and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of my Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post this information on the HOPE Network website and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with my office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of my office. I will not retaliate against you for filing a complaint.

For more information about HIPAA, you may contact the following:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257 or (877) 696-6775

ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

- TREATMENT
- PAYMENT
- HEALTH CARE OPERATIONS

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____