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NOTICE OF PRIVACY PRACTICES (HIPAA)

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) you have certain rights to privacy regarding your Protected Health Information (PHI). This information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments.

If there is a breach of your confidentiality, then I must inform you and Health and Human Services. A breach means that information has been released without authorization or legal authority unless I can show that there was a low risk that the PHI was compromised because the unauthorized person did not view it or it was de-identified.

If you are self-pay, you may restrict the information sent to insurance companies.

Most uses of disclosures of psychotherapy notes and PHI require authorization. Other uses and disclosures not described in the notice will be made only with your written authorization. You must sign an authorization (release of information form) for releases that are not mentioned in this Privacy Notice (such as mandated reporting of child abuse, reporting of elder abuse, reporting of impaired drivers, etc.)

Our website contains a more complete *Notice of Privacy Practices* containing a detailed description of the uses and disclosures of your health information. You have the right to review such a *Notice of Privacy Practices* before signing this consent, and we have the right to change it from time to time.

You have the right to request limitations on specific uses and disclosures of your PHI. Although we are not obligated to accept these limitations, we will comply with any limitations we agree upon.

You may revoke this consent at any time in writing. However, the revocation will not affect any prior uses or disclosures of PHI made under this.

Please indicate your preferences for how we may contact you

Appointment Confirmations

☐ Phone ☐ Email ☐ Text message

Messages

☐ Home or Cell phone Number: _____ ☐ Home answering machine

Family Discussions May we discuss your medical condition with designated family members?

☐ Yes ☐ No

If yes, please name the allowed members: _____

Consent

By signing below, I acknowledge that I have read and understood this form and agree to the use and disclosure of my PHI as described above.

Patient Name (Print): _____ Date _____

Signature of patient or legal guardian _____

Relationship to Patient: ☐ Patient ☐ Spouse ☐ Parent ☐ Child ☐ Guardian ☐ Other _____