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NOTICE OF HIPAA PRIVACY PRACTICES

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

PURPOSE: This Notice of Privacy Practices describes how I may use and disclose your Protected Health Information to conduct treatment, obtain payment or carry out other healthcare operations and for other purposes permitted or required by law. "Protected Health Information" is information that may identify the client and that relates to the client's past, present or future physical or mental health, and may include name, address, and other identifying information.

I am required to give you this Notice and to maintain the privacy of your Protected Health Information. I must abide by this notice but I reserve the right to change the privacy practices described in it in response to changing legal requirements. You may request a copy of this notice at any time.

If you believe your privacy rights have been violated, you may complain to me or to the U. S. Secretary of Health and Human Services. To file a complaint with me, you may send a letter describing the violation to the address above. There will be no retaliation, effect on the services provided to you or other negative effect for filing a complaint.

ACKNOWLEDGMENT: You will be asked to sign an ACKNOWLEDGMENT of receipt of this Notice.

Your Privacy Rights. You have the following rights relating to your Protected Health Information and may:

Obtain a current copy of this Notice.

Inspect or obtain a copy of your records. Your request to obtain a copy of your records must be made in writing.

Request that I amend your record if you feel the information is incomplete or incorrect.

Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.

I will obtain your written permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing.

My Responsibilities.

I am required to protect the privacy of your Protected Health Information, abide by the terms of the Notice. and make the Notice available to you.

Examples of Uses and Disclosures.

Law Enforcement: I must disclose your Protected Health Information for law enforcement purposes as required by law.

As Required by Law: I must disclose your Protected Health Information when required by federal, state or local law.

Abuse or Neglect: I must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.

Legal Proceedings: I may disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process.

To Avoid Harm: I may disclose information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.

By your signature below, you indicate that you have received and read and agreed to this document. Please feel free to keep a copy of this form for yourself.

Signature _____ **Date** _____