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Health Information Portability and Accountability Act (HIPAA) Privacy Policy

This document contains important information about federal law, the Health Information Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that we provide you with a Notice of Privacy Practices (this notice) for use and disclosure of PHI for treatment, payment, and health care operations. The notice explains HIPAA and its application to your PHI in greater detail.

The law requires that we obtain your signature acknowledging that we have provided you with this notice. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it.

Use and Disclosure of Protected Health Information:

- **For Treatment:** We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information.
- **For Payment:** We may use and disclose your health information to obtain payment for service provided to you
- **For Operations:** We may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel may be of interest to you.

  For HIV Disclosure: Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, public health authorities are authorized to collect and receive private health information “for the purpose of preventing or controlling disease” and in the “conduct of public health surveillance...” without patient or provider consent or authorization other than state or local public health law. This clause authorizes providers to report HIV/AIDS cases to the HIV epidemiology program without obtaining patient consent and it authorizes health department personnel to review medical records and any other source of information needed to report the case.

ANY other disclosure of HIV-related information must be made on the "HIPAA- compliant authorization for release of medical information and confidential HIV-related information." State law prohibits any further disclosure of HIV-related private health information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Client Rights:

- **Right to Treatment**: You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- **Right to Confidentiality:** You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction that you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.50 per page. Please make your request well in advance and allow 2 weeks to receive copies. If we refuse your request to access your records, you have the right of review, which we will discuss with you upon request.
- **Right to Amend:** If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is appropriate. If we refuse to do so, we will provide you with reasoning for such a choice within 60 days.
- **Right to a Copy of This Notice:** If you receive this paperwork electronically, you have a copy in your email/portal. If you completed this paperwork in office, you may request a copy at any time.
- **Right to an Accounting-** You generally have the right to receive an accounting of disclosures of PHI regarding you. At your request, we will discuss with you the details of the accounting process.
- **Right to Choose Someone to Act For You:** If someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take action.
- **Right to Choose:** You have the right to decide not to receive services with us. If you wish, we will provide you with the name of other qualified professionals.

- **Right to Terminate:** you have the right to terminate services with us at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with us before termination, or at least contact must be made by phone letting us know that you are terminating services.
- **Right to Release Information With Written Consent:** WIth your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not we think releasing the information in question to that person or agency may be harmful to you.

Provider Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practice with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide you with a revised notice prior to your next appointment.

Client Name_____

Client Signature_____Date _____

Guardian Name (If applicable) _____

Guardian SIgnature (if applicable)_____ Date_____