

## NOTICE OF PRIVACY PRACTICES

**This notice describes how health information about you may be used and disclosed and how you can get access to this information.**

**Please review it carefully. The privacy of your health information is important to us.**

### **LEGAL DUTY**

It is required by law (HIPAA) to maintain the privacy of your health information. It is also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/05/17 and will remain in effect until revised.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of this Notice at any time.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, or with your authorization. We will also disclose health information about you when required to do so by federal, state, or local law. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. Payment can be collected using the Square service.

**Your Authorization:** You may give written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. Any authorization to release information will expire no more than one year from the date of the signed release but there can be a predetermined date of expiration set while creating the release.

**To Your Family and Friends:** We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only with a signed release by you. You must agree that we may make this contact.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons, or similar process.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if there is reasonable belief or suspicion that a minor or a vulnerable adult are a possible victim of abuse or neglect. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or client under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, emails, postcards, or letters).

## **CLIENT RIGHTS**

**Inspect and Copy:** You have the right to look at or get copies of your health information, with limited exceptions. (You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you \$ 1.00 for each page, \$ 25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, and certain other activities, for the last 6 years. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Request Confidential Communications:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. For example, you can ask that we only contact you at work or by mail. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information if you believe that the health information about you is incorrect or incomplete. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if it is not in writing or does not include a reason to support the request.

## **File a complaint**

You may file a complaint if you feel your privacy rights have been violated. You may file this complaint through the Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling. You will not be penalized for filing a complaint.

## **Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice available at each appointment. You may also request an electronic copy sent via email.

## Acknowledgment of Notice of Privacy Practices

By signing below, I am acknowledging that I have been provided with a copy of the Notice of Privacy Practices form.

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Printed Name of Client/Legal Guardian

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Signature of Client/Legal Guardian

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Date