HIPAA NOTICE OF PRIVACY PRACTICES

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

1. YOUR RIGHTS WITH RESPECT TO YOUR CONFIDENTIAL INFORMATION
   a. To inspect, copy (including a paper copy) and receive information.
   b. To request the right to amend your information (although we are not required to do so)
   c. To receive an accounting of non-routine or non-authorized disclosures of your information for 7 years
   d. To request a restriction on certain uses and disclosures of your information (although we are not required to do so)
   e. To file a complaint if you believe your rights have been violated*

2. THE FOLLOWING ARE VARIOUS USES AND DISCLOSURES OF YOU CONFIDENTIAL INFORMATION THAT MAY BE USED BY YOUR THERAPIST (specific medical consent is required)

   a. For your medical treatment
      i. For example, your health care team may share your medical information including their observations, in order to determine how you are responding to treatment
      ii. For example, we may use your health care information to contact you regarding an appointment

   b. To bill for your medical services
      i. For example, a bill may be sent to your insurance company which contains your diagnosis, procedure performed or supplies used.

   c. For our operational purposes
      i. For example, your information may be used in connection with quality improvement activities in order to improve the quality and effectiveness of the services we provide
      ii, For example, our business associates may need may need your confidential
      information so they can perform the job we asked them to do. Business associates include accreditation agencies, state hospital associations, our attorneys and accountants.

3. USES AND DISCLOSURES OF YOUR CONFIDENTIAL INFORMATION WE

May MAKE UNLESS YOU OBJECT

a. To family and friends involved in your care
b. With respect to treatment alternatives or other health related benefits which may be of interest to you

4. USES AND DISCLOSURES OF YOUR CONFIDENTIAL INFORMATION WE MUST MAKE (Without your consent)

a. When required by state or federal law
b. To state and federal public health authorities for disease prevention
c. To protective service agencies authorized to receive reports of abuse, neglect And domestic violence
d. To governmental oversight agencies
e. When required pursuant to a court order
f. For law enforcement purposes
g. To a coroner, medical examiner or funeral director for the purpose of carrying out their duties
h. To organ procurement organizations
i Pursuant to established research protocols (IRB or Privacy Board approval)
j. When required to avert a serious threat to health or safety
k. In connection with workers compensation programs

Any other uses other than what is described above is prohibited unless specific authorization is given by you. You have the right to revoke such authorization at any time in writing, except to the extent we have already relied on it.

5. OUR DUTIES

a. We are required to maintain the confidentiality of your medical information and to provide you with notice of our legal duties and privacy practices
b. We are required to abide by the terms of this Notice
c. We reserve the right to change the terms of this Notice and will post the new Notice when it becomes effective
d. We cannot ask you to waive your rights, as identified in this notice, as a condition fort treatment or payment

6. *RIGHT TO COMPLAIN

a. You may complain to the office manager if you believe your rights identified in this Notice have been violated. Contact our office for the form for filing a complaint
b. If you are unhappy with how your complaint was handled, you may contact the Secretary of Health and Human Services.
c. The law prohibits any retaliation for filing a complaint

7. FOR FURTHER INFORMATION

You may contact Judith Mishkin Miller, L.C.S.W., B.C.D. at 828-658-3409 for any further information with respect to this policy.

I have read and understand the above Notice.

_____ _____

Patient Signature (or legal representative) Date

_____ _____

Patient Signature (or legal representative) Date

_____

Witness - If patient refuses to sign