NOTICE OF PRIVACY PRACTICES

YOUR PRIVATE HEALTH INFORMATION

Our office keeps records of the mental health care and services provided to you in order to help provide quality care and services. Because of the sensitivity of health records, we are required by state and federal law to maintain the privacy of your health information. We are also required to give you this *Notice of Privacy Practices* concerning your health information.

USE AND DISCLOSURE OF INFORMATION

We use and disclose information about you for treatment, payment and health care operations. For example:

- ***Treatment:*** We may share all or part of your health information with another health care provider providing treatment to you.
- ***Payment:*** Our office keeps billing records that include payment information and documentation of the services provided to you. We may use and disclose your health information to obtain payment from you, your insurance company, Medicaid, or other third party payment provider.
- ***Health Care:*** Operations We may use and disclose your health care information to improve quality of care, train our staff, provide customer service, mange costs and conduct business duties.

Federal guidelines do not require our office to have your written consent to disclose your health care information when it is for payment, treatment or health care operation purposes. However, because your private health information is sensitive, we will keep disclosures to a minimum based on our professional judgment. We will also have you sign a consent and/or authorization document to request information from other sources and to release health information to outside parties.

HIPAA AND YOUR PRIVACY

The ***Health Insurance Portability Accountability Act*** was enacted to maintain the confidentiality of personal medical information. You are entitled to request information about your records or about the privacy of your information, or revoke your authorization at any time with a written request.

HIPAA permits us to disclose your health information without your written consent when it is for treatment payment or health care operations. Protecting your privacy is important to us. We follow federal and state laws, professional codes of ethics and industry best practices to provide the highest quality care.

Information may be disclosed to family members or others directly involved in your care or payment for your care without your written consent. Examples include parents of dependent children, legal guardians, and assisted living/nursing home staff, Social Security Disability Officer, Worker's Compensation, and Medicaid.

Third parties having access to your personal medical information must follow physical, electronic, and procedural safeguards that comply with HIPAA protections for confidentiality.

Other limited situations allowing us to use or disclose health information without your signed authorization include:

- Public health purposes such as reporting communicable diseases, work-related illnesses, or reporting adverse reactions to medication, etc.
- Protection of victims of abuse, neglect or domestic violence
- Health oversight activities such as investigations, audits and inspections
- Requests from a court order
- Worker's Compensation
- Reduction or prevention of a serious threat to public health and safety

**We reserve the right to make changes to this notice and to make the privacy practices effective for all information we maintain. Current notices will be posted in our office. You may also request a copy at any time.*

Notice of Privacy Practices

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Summary

By law we are required to provide you with our Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed by. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

- The right to copy and inspect your information.
- The right to request corrections to your information.
- The right to request your information be restricted.
- The right to request confidential communications.
- The right to a paper copy of this notice.

We want to ensure that your health information is secure with us. This notice contains information about how we will insure that your information remains private.

If you have any questions about this, please contact us at our office during regular business hours.

I herby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that if I have questions or concerns regarding my privacy rights that I may contact Positive Connections Plus. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changed in anyway.

Patient Authorization for Third Party Reimbursement of Provider

I request that payment of authorization Medicare, Medicaid, and/or Private Insurance benefits on my behalf of Positive Connections Plus for services. I authorize any holder of medical information about me to be released to the centers for Medical Services, and/or any third party payer (s) and their agents, any information needed to determine these benefits payable for related services.

_____ _____

Patient or Representative Name (Print) Patient or Representative Signature

_____ _____

Date Patient refused/unable to sign because