

NOTICE OF MY PRIVACY PRACTICES

Please read this carefully. You will be asked to sign affirming that you have read it.

As a licensed mental health provider, I am required by federal and state laws to protect for privacy. The **Health Information Portability and Accountability Act (HIPAA)** establishes limits on how your health information may be used and shared; and how it must be protected. When Florida laws protecting your health records are more restrictive than federal laws, I must abide by the Florida laws.

The following **Notice of My Privacy Practices** will tell you about the ways I may use and share mental health information about you. I also describe here your rights and my duties regarding the use and disclosure of your mental health information.

My Pledge to You Regarding Your Mental Health Information

The privacy of your mental health information is important to me. I create a record of the treatment you receive from me. This record enables me to provide you with quality treatment and to comply with certain legal requirements. I understand that this information is personal and I am committed to protecting it.

This Notice of My Privacy Practices describes:

- How and to what extent the privacy of your Protected Health Information is guaranteed.
- How your Protected Health Information may be used and disclosed.
- How you may access portions of your Protected Health Information, and the procedure for doing so.

Your Protected Health Information

Your Protected Health Information includes any *individually identifiable information* I create or receive about you. Specifically it includes:

- Identification of symptoms, diagnosis, medications, and your prognosis.
- Appointment times and dates with session summaries.
- Claims to you and/or your insurance company for payment of services provided; payment history.

My notes of your sessions are in a separate category with their confidentiality so protected that you must give me specific written permission to release them.

Use and Disclosure of Your Protected Health Information

Without your specific written consent:

- I will not share with your managed care company (insurance) or Employee Assistance Program the Protected Health Information required to obtain authorization to treat you and to bill for your treatment services. However, if you refuse to provide this consent, you will be personally responsible for the cost of your care.
- I will not share your Protected Health Information with another therapist or treatment facility.
- I will not share your Protected Health Information with any other individual, including family members, except in the case of minor children.
- I am required to report child and elder abuse and/or neglect to the proper authorities. This report may of necessity include your Protected Health Information.
- I am required to take action, including the release of your Protected Health Information, if I believe that you or someone else is imminently at risk for harm.
- I may share your Protected Health Information with individuals or entities that participate in the management of my practice. Each of these people has agreed to abide by the terms of my Notice or Privacy Practices.

Without your specific written consent:

- I may release your Protected Health Information to medical personnel in a medical emergency.
- I may release your Protected Health Information for these additional purposes: public health, health/safety activities, national security, military activities, patient directories, law enforcement, judicial proceedings, correctional facilities, healthcare oversight, workers' compensation, coroner/funeral activities, family members or others involved in your care, research, when required by law.

Your Privacy Rights

*With the exception of the purposes listed above, you have the **right to decide** if your Protected Health Information is given out to a third party and to specify what information is to be given. You do this by completing and signing the Authorization to Use and/or Disclose Protected Health Information. You may revoke this consent at any time.*

You have the **right to review** and get copies of your Protected Health Information. Your request must be in writing. There may be charges for copying and postage. Your request may be denied if I think that giving you your Protected Health Information may endanger your life or physical safety or that of another person.

You may **request that corrections or additions** be made to your Protected Health Information if you believe that there is a significant omission. You or another health professional may add information to your record, *but nothing will be removed from your Protected Health Record*. Under HIPAA regulations, *your request does not require me to change anything in your health records*. However, if I deny your request, I will provide you with a written explanation. If I accept your request to change or add information, I will make reasonable efforts to tell others, including people you name, of the change/addition and to include the change/addition in any future sharing of your Protected Health Information.

You may **request additional restrictions** on my use or disclosure of your Protected Health Information. *But, I, as your health care provider, am not required to agree to these additional restrictions if I have substantial reasons for not honoring your request.*

You may **request that I use an alternative way to communicate with you in a confidential manner** or communicate with you at an alternative location about your Protected Health Information. Make your request in writing to my Privacy Officer.

You may **obtain a list of the times I have disclosed your health information** for purposes other than treatment, payment, healthcare operations and other specified exceptions.

You will **receive a paper copy of my Notice of Privacy Practices** when you request it in writing from my Privacy Officer.

You have the **right to file a written complaint** if you believe I have violated your privacy rights. To file such a complaint, contact my Privacy Officer at 727-863-3545. Or, you may submit a written complaint to the U.S. Department of Health and Human Services. If you choose to do this, we will provide you with the address to file your complaint to the U.S. Department of Health and Human Services. Your decision to file a complaint will not be held against you in any way. However, it may be necessary for us to discuss whether it is possible to continue in a therapeutic relationship.

My Legal Duty

I am required to abide by the terms of this notice. However, I reserve the right to change my privacy practices and the terms of this notice at any time provided the changes are permitted by law or to meet any new requirements implemented by law for the benefit of your Protected Health Information.

Before I make any important changes to my privacy practices, I will revise this notice and make the new notice available to you on your first visit following the revisions.

Any changes to my privacy practices and the new terms of this notice will be effective from the date of the revision forward for all mental health information I keep.

You may have a copy of this notice by requesting it from me or from my Privacy Officer.