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EXPLANATION OF PRIVACY PRACTICES

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

Please read this notice carefully and sign and date it on the second page.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by me in any form, whether electronically, on paper, or orall**y,** are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your protected health information is used. **HIPAA** provides penalties for covered entities that misuse personal health information.

As required by **HIPAA,** this statement explains how the requirements for privacy of your protected health information and how it may be used and disclosed.

Your medical records and information may be disclosed only for each of the following purposes: treatment, payment, and health-care operations.

Treatment means providing, coordinating, or managing your health care and other services related to your health care. An example of this would be consultation with another health care provider, such as your family physician, another therapist or therapist supervisor, and/or a psychiatrist.

Payment means activities such as obtaining reimbursement for your services, confirming coverage, billing or collection activities, and utilization review.

Health Care Operations are activities that relate to the performance and operation of the private practice. Examples of health care operations are quality assessment and improvement activities, cost management analysis, and customer service.

Your health information may also be used to create and distribute unidentified health information about treatment alternatives or other health related benefits and services that may be of interest to you. I may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services pertinent to your treatment. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

You have the following rights with regard to your private health care information, which you can exercise by presenting a written request to the privacy office.

* The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. I am not, however, required to agree to a requested restriction, in particular in a situation where you request that I do not keep case notes and other personal information that is required under the law governing my license (FL491). If we do agree to some restriction, we must abide by it unless it is removed in writing.

* The right to reasonable requests to receive confidential communications of protected information from us by alternative means or at alternative locations.

* The right to inspect and copy your protected health information.

* The right to amend your protected health information.

* The right to receive an account of disclosure of protected health information.

* The right to obtain a paper copy of this notice from me upon request.

I have received, read, and understand your *Notice of Privacy Practices* explanation containing a complete description of the uses and disclosures of my health information. I understand that Dr. Sherman has the right to change or update this notice from time to time, and that I may contact her organization at any time to obtain a current copy of the *Notice of Privacy Practices* at the address on this letterhead.

I understand that I may request *in writing* that Dr Sherman restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand that she is not required to agree to my personal restrictions, but if you do agree then you are bound to abide by them.

Patient Name ____

Relationship to Patient ____

Signature ____

Date ____

Office Use Only: I attempted to obtain the patient's (or guardian's) signature in acknowledgement of the Notice of Privacy Practices. I was unable to obtain the patient's signature for the reason(s) documented below.

Date__________Initials________________Reason______________________________

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