HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW THE FOLLOWING CAREFULLY:

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- **Treatment** means providing, coordinating, or managing health care and/or educational and/or related services, by one or more health care providers. An example of this would be a speech and language therapy session.

- **Payment** means such activities as billing or collections activities and utilization review. An example of this would be sending you written documentation regarding payment for your child’s visit.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, information about other services, or other health-related benefits and services that may be of interest to you.

We will disclose your protected health information to any person you identify that is listed on your Consent for Exchange, Obtain or Release Information Form. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We will use and disclose your protected health information when required by federal, state, or local law. There are certain situations in which a speech-language pathologist is required by ethical standards to reveal information obtained during a session to persons or agencies even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, we are required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, we are required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if we are required by a court of law (court order) to turn over records to the court or if we are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with a Consent for Exchange, Obtain, or Release Information Form upon request. A separate Form will be needed for each request. Your written authorization is valid until it expires or is revoked.

Please sign to indicate that you understand the operation use of your information for treatment, payment, and health care operations as stated above.

______________________________ Print Name of Client

______________________________ Date

______________________________ Signature of Client or Legal Representative

______________________________ Relationship to Client