HIPAA PRIVACY FORM

This notice describes the manner in which your medical information may be utilized, disclosed, and safeguarded. It is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations by the Department of Health and Human Services (HHS). I am committed to protecting the privacy of all of my client’s health information, including, but not limited to, billing information, health records, collateral contact information, and demographic information. I am required by law to maintain the privacy of your health information and to provide you with this notice of my privacy practices regarding the health information I collect and maintain.

I maintain written health records in a locked file cabinet in my office. Payments received via credit card service are done so utilizing a recognized HIPAA compliant service.

Please understand that there are certain circumstances when it may be legally permissible for me to release your personal information without your consent. These examples include but are not limited to:

* Concerns about imminent danger to self or others
* Concerns about suspected elder or child abuse or neglect
* The presentation of a Court Order signed by a Judge releasing my records
* The request from your insurance company for billing purposes

If we decide that I should speak with previous or current treaters, family, or other collateral sources of information, you will be required to complete and ink sign a Release of Information form found on my website and return it to me.

I have read, fully comprehend, and agree to the HIPAA privacy policies outlining how my health information will be handled.

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Signature of patient (if at least 18 years old)

Signature of parent or guardian (if under 18 years old)

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Printed Name of Patient

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Date