

Notice 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 REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is and can be reached by phone at or by e-mail at SFHInstitute@aol.com.

I acknowledge I have received and understand these privacy practices by my signature below.

Signature

Date

Witness

Date

Consent to Use and Disclose Your Protected Health Information

This form is an agreement between you, and me/us, When we use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information” (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others (such as insurance companies) to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at (919) 802-0312.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our office. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative’s authority

Signature of authorized representative of this office

Date of NPP: _____

Copy given to the client/parent/personal representative