620 Colonial Park Dr
Suite 100
Roswell, GA 30075
P: 678-439-0017
F: 678-884-0761

Health Information Portability and Accountability Act (HIPAA) Notice of Privacy Policy

This document contains important information about federal law, the Health Information Portability and Accountability Act (HIPAA), which provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for treatment, payment, and health care operations.

HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for the use and disclosure of PHI for treatment, payment, and healthcare operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that we obtain your signature acknowledging that we have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion before signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have acted in reliance on it.

Use and Disclosure of Protected Health Information:

● **For Treatment** – We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another healthcare provider, we will have you sign an authorization for the release of information. Furthermore, authorization is required for most uses and disclosures of psychotherapy notes.

● **For Payment** – We may use and disclose your health information to obtain payment for services provided to you.

● **For Operations** – We may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

For HIV Disclosure- Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, public health authorities are authorized to collect and receive private health information "for the purpose of preventing or controlling disease" and in the "conduct of public health surveillance..." without patient or provider consent or authorization other than state or local public health law. This clause authorizes providers to report HIV/AIDS cases to the HIV Epidemiology Program without obtaining patient consent and it authorizes health department personnel to review medical records and any other source of information needed to report the case.

Any other disclosure of HIV-related information must be made on the "HIPAA- Compliant Authorization for Release of Medical Information and Confidential HIV-Related Information". State law prohibits any further disclosure of HIV-related private health information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

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Client Rights:

● **Right to Treatment** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

● **Right to Confidentiality** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.

● **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

● **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

● **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and the release of information must be completed. Furthermore, there is a copying fee charge of $25.00. Please make your request well in advance and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right to review them, which we will discuss with you upon request.

● **Right to Amend** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You must make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.

● **Right to a Copy of This Notice** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.

● **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI regarding you. At your request, we will discuss with you the details of the accounting process.

● **Right to Choose Someone to Act for You** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.

● **Right to Choose** – You have the right to decide not to receive services with us. If you wish, we will provide you with the names of other qualified professionals.

● **Right to Terminate** – You have the right to terminate services with us at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with us in session before terminating or at least contact must be made by phone letting us know you are terminating services.

● **Right to Release Information with Written Consent** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not we think releasing the information in question to that person or agency might be harmful to you.

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Clinician Duties:

● We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices concerning PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide you with a revised notice in the office during our session.

Client's printed Name: _____

Client's Legal Representatives Name: _____

If the client is a minor / has a guardian:

Parent / Guardian Printed Name: _____

The CLIENT MUST sign the consent if they are able to do so. The only exceptions are if the client is a minor or has a legal document giving permission for someone else to sign on their behalf.

_____

Client / Clients LEGAL Representative / Parent or Guardian Signature

_____

Date