



**The Elements Counseling Services, PA**

**Phone: 704-277-3801**

### PRIVACY NOTICE

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.

Effective: July 1, 2004

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has ordered the development of rules for medical records security and privacy and standardization of medical insurance claim information. As a result, I am required by law to maintain the privacy of your health information and to provide you with this notice of my legal duties and privacy practices with respect to your health information.

#### Allowable Uses or Disclosures of Information

The Elements Counseling Services, PA, is allowed to use or disclose your health information without your written authorization for the following activities:

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| To prevent serious threat to health or safety.  | Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety.   |
| To report abuse or neglect.   | Disclosures to public health authorities to report child or elder abuse or neglect.  |
| For emergency treatment.  | Disclosure of health information about you if you need emergency treatment   |
| To communicate with family members or other parties who have a legitimate role in therapeutic services offered or with another person designated by the client. | Disclosure of information to involved parties that are directly involved in your treatment related to the minimum, basic health information regarding your symptoms, assessment, diagnosis, treatment plan, and treatment recommendations. |
| To respond to a court order and subpoena.   | Disclosures in response to a court or administrative order, subpoena, or other lawful process.   |
| For health care operations/business activities.   | Your personal health information may be shared with third parties that perform various business activities (e.g., billing services) provided that a written contract to safeguard the privacy of your health information is in place.      |
| To obtain payment for services.   | Before and during the time of your treatment, I may share details with your health plan to ask for approval, authorization, or payment for services.   |
| For HHS investigation.  | Disclosures of your health information to the Department of Health and Human Services  |

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|  | (DHHS) to investigate or determine my compliance with the HIPAA privacy rule. |
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Except as described in this notice, other uses and disclosures will be made only with your written authorization. Any health information used or disclosed to other parties will be limited to the "Minimum Necessary." If written authorization is given, you may revoke your authorization, except when disclosures by myself have already been authorized and made.

Your Rights

The following are your rights with respect to your health information.

- ❖ You have the right to ask to restrict uses or disclosures of your information for treatment and payment. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. Please note that while I will try to honor your request, I am not required to agree to any restriction.
- ❖ You have the right to ask to receive confidential communications of information in a different manner or at a different place (for example, by sending information to a P. O. box instead of your home address).
- ❖ You have the right to see and obtain a copy of your medical record. You do not have a right to inspect or obtain copies of psychotherapy notes. In certain limited circumstances, I may deny your written request to inspect and copy your medical record and/or charge a reasonable, cost-based fee for copies. Your request must be in writing.
- ❖ You have the right to amend your medical record if you believe the health information about you is wrong or incomplete. If I deny your written request to amend your record, you may have a statement of your disagreement added to your medical record.
- ❖ You have the right to ask me for a list of disclosures I have made of your record after April 14, 2003. This accounting will not include disclosures of information for treatment, payment, and health care operations purposes or other disclosures of which federal law does not require me to provide an accounting.
- ❖ You have the right to a paper copy of this notice.

Exercising Your Rights

- ❖ Contact me if you have any questions about this notice or want to exercise any of your rights.
- ❖ If you believe your privacy rights have been violated, you may complain to me and to the Secretary of Health and Human Services. Complaints should be forwarded to:

Region IV, Office for Civil Rights  
 U.S. Department of Health and Human Services  
 Atlanta Federal Center Suite 3B70, 61 Forsyth St. SW  
 Atlanta, GA 30303-8909 (404) 562-7886 Fax: (404) 562-7881  
 There will be no retaliation for filing a complaint with the Secretary of DHHS.

I have read this notice \_\_\_\_\_ Date \_\_\_\_\_  
 Signature