Notice of Privacy Practices

Protected health information (PHI) held by a HIPAA covered entity. Complete every bracketed field before you distribute this notice.

Practice name _____ Effective date _____

Practice address _____

Phone _____ Email _____ Website _____

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.

This header is required by 45 CFR 164.520(b)(1)(i). It must appear prominently, in this wording, at the top of your notice.

1. WHO FOLLOWS THIS NOTICE

This notice describes the privacy practices of [Practice name], its employees, its clinical and administrative staff, and any workforce member or trainee working at our locations. It also covers the business associates we hire to perform services on our behalf. Those business associates are required by written contract to protect your information to the same standard we do.

We are required by law to keep your protected health information private, to give you this notice of our legal duties and privacy practices, and to follow the terms of the notice that is currently in effect.

2. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your protected health information for treatment, payment, and health care operations without your written authorization. An example of each is below.

Treatment. We use your health information to provide, coordinate, and manage your care. For example, a clinician reviews your medical history before a procedure, or we send your records to a specialist we refer you to.

Payment. We use your health information to bill and collect payment for the care you receive. For example, we send a claim with your diagnosis and treatment details to your health plan so it can determine coverage.

Health care operations. We use your health information to run our practice safely and lawfully. For example, we review records for quality assessment, staff training, licensing, audits, and compliance activities.

Appointment reminders and care options. We may contact you about appointments, treatment alternatives, or health-related benefits and services that may interest you. Tell us if you would prefer that we do not.

People involved in your care. We may share information relevant to your care with a family member, friend, or personal representative you identify. If you are not present or are unable to agree, we use professional judgment to decide whether sharing is in your best interest.

3. USES AND DISCLOSURES PERMITTED OR REQUIRED BY LAW

The Privacy Rule also permits or requires us to use and disclose your health information without your authorization in the situations below. We disclose only what the law allows in each case.

- When required by federal, state, or local law.
- For public health activities, including reporting disease, injury, vital events, and product safety issues to authorities.
- To report suspected abuse, neglect, or domestic violence to an agency authorized to receive it.
- For health oversight activities such as audits, investigations, inspections, and licensure actions.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes permitted by the Privacy Rule, such as identifying a suspect or reporting a crime on our premises.
- To coroners, medical examiners, and funeral directors so they can carry out their duties.
- To organ procurement organizations for donation and transplantation.
- For research approved by an institutional review board or privacy board that has reviewed the privacy protections.
- To prevent or lessen a serious and imminent threat to the health or safety of you or the public.
- For specialized government functions, including military, national security, and correctional institution activities.
- As authorized by, and to the extent necessary to comply with, workers compensation and similar programs.

Fundraising. We may contact you for fundraising, and you have the right to opt out of receiving those communications. Opting out will not affect your treatment or payment. [Delete this paragraph if your practice does not fundraise.]

4. USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

The following uses and disclosures are made only with your written authorization:

- Most uses and disclosures of psychotherapy notes.
- Uses and disclosures for marketing purposes, including any communication for which we receive payment from a third party.
- Any sale of your protected health information.
- Any other use or disclosure not described in this notice.

You may revoke an authorization in writing at any time. A revocation stops future uses and disclosures under that authorization. It does not undo anything we already did while the authorization was in effect.

5. OUR MINIMUM NECESSARY STANDARD

When we use or disclose your protected health information, and when we request it from another provider or plan, we limit the information to the minimum necessary to accomplish the purpose. We assign staff access by role, so each person can see only the information their job requires.

The minimum necessary standard does not apply to disclosures to or requests by a health care provider for treatment, to disclosures made to you, to disclosures made under an authorization you signed, to disclosures to the Secretary of Health and Human Services, or to uses and disclosures required by law.

6. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Get a copy of your records. You may inspect and get a copy of the health information we use to make decisions about your care. If we keep the information electronically, you may ask for an electronic copy. We may charge a reasonable, cost-based fee. We will respond within 30 days and may take one 30-day extension if we tell you why.

Ask us to correct your records. You may ask us to amend information you believe is incorrect or incomplete. We may deny the request in certain cases, and if we do, we will explain why in writing and tell you how to file a statement of disagreement.

Get a list of disclosures. You may request an accounting of certain disclosures we made in the six years before your request. The accounting excludes disclosures for treatment, payment, and health care operations, and several other categories the Privacy Rule lists. One accounting in any 12-month period is free.

Ask us to limit what we use or share. You may request a restriction on the information we use or disclose for treatment, payment, or health care operations. We do not have to agree, with one exception: if you pay for an item or service in full out of pocket, we must honor your request not to disclose that information to your health plan.

Ask for confidential communications. You may ask us to contact you at a specific phone number or address, or by a specific method. We will accommodate reasonable requests and will not ask you why.

Get a paper copy of this notice. You may ask for a paper copy of this notice at any time, even if you agreed to receive it electronically. We will give you one promptly.

Be notified of a breach. We will notify you if a breach occurs that may have compromised the privacy or security of your unsecured health information.

Choose someone to act for you. If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will verify their authority first.

To exercise any right in this section, submit a written request to our Privacy Officer using the contact details in section 10.

7. OUR DUTIES AS A COVERED ENTITY

- We are required by law to maintain the privacy and security of your protected health information.
- We must give you this notice of our legal duties and privacy practices with respect to your information.
- We must follow the terms of the notice that is currently in effect.
- We must notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- We may not use or disclose your information other than as described here, unless you tell us we may in writing.
- If you give us written permission and later change your mind, you may revoke that permission in writing at any time.

8. CHANGES TO THIS NOTICE

We may change the terms of this notice at any time, and the new terms will apply to all information we hold, including information we created or received before the change. The current notice will always be posted in our reception area and on our website, and it will show its effective date. You may request a copy of the current notice at any visit.

9. HOW TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer using the contact details below. You may also file a complaint directly with the U.S. Department of Health and Human Services.

> Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201. Telephone 1-877-696-6775. Complaint portal: www.hhs.gov/ocr/complaints

A complaint must generally be filed within 180 days of when you knew, or should have known, that the act occurred. We will not retaliate against you, and we will not deny you care, for filing a complaint.

10. PRIVACY OFFICER AND CONTACT DETAILS

Privacy Officer name _____ Title _____

Phone _____ Email _____

Mailing address for written requests _____

11. STATE LAW AND OTHER MORE PROTECTIVE REQUIREMENTS

HIPAA sets a federal floor, not a ceiling. Where state law or another federal law gives your information greater protection, we follow the stricter rule. Use the space below to describe the requirements that apply where you practice, and delete the rest.

- California: Confidentiality of Medical Information Act (Cal. Civ. Code sec. 56 et seq.).
- Texas: Medical Records Privacy Act (Tex. Health and Safety Code ch. 181).
- New York: Public Health Law sec. 18 and article 27-F for HIV-related information.
- Substance use disorder records held by a Part 2 program: 42 CFR Part 2.
- Any additional state notice, consent, or authorization requirement that applies to your specialty.

State-specific disclosures for this practice:

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Acknowledgement of receipt

Keep this page in the patient record. A provider with a direct treatment relationship must make a good faith effort to obtain a written acknowledgement of receipt at or before the first service delivery.

I acknowledge that I have received a copy of the Notice of Privacy Practices for [Practice name]. The notice describes how my protected health information may be used and disclosed, and how I can get access to that information. I understand that the practice may change the notice, and that a current copy is available on request.

Patient name (print) _____ Date of birth _____

Patient signature _____ Date _____

Personal representative name _____ Relationship to patient _____

Personal representative signature _____ Date _____

FOR OFFICE USE ONLY - GOOD FAITH EFFORT

If the patient did not sign, record the effort made and the reason. 45 CFR 164.520(c)(2)(ii).

Notice offered by (staff name) _____

Date offered _____

Reason acknowledgement was not obtained _____

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