ELISABETH A. EDWARDS, MA, LMHC, LMFT

NOTICE OF PRIVACY PRACTICES

The following notice is an introduction to your rights and responsibilities as a client of mental health services. This notice, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), describes how your medical information may be used and disclosed and how you can get access to this information.. Elisabeth A. Edwards, MA, LMHC is required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices to your health information.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to Elisabeth A. Edwards, MA, LMHC in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information.

Without specific written authorization, I am permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

·*Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

·*Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

·*Health Care Operations* include the business aspects of running the practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of my documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. I will use and disclose your PROTECTED HEALTH INFORMATION when I am required to do so by federal, state or local law. I may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if I have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. I may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. I may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, I will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization. You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to Elisabeth A. Edwards, MA, LMHC at 1505 NW 16th Avenue, Gainesville, FL 32605:

·The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.

·The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from me by alternative means or at alternative locations.

·The right to request an amendment to your PROTECTED HEALTH INFORMATION.

·The right to receive an accounting of disclosures or PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

·The right to obtain a paper copy of this notice from me upon request. I am required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of my legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that I maintain. Revisions to the Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with Elisabeth A. Edwards, MA, LMHC at 1505 NW 16th Avenue, Gainesville, FL 32605, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. I will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201
877.696.6775 (toll-free).

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HIPAA NOTICE OF PRIVACY PRACTICES RELEASE

I have read and understood the privacy practices. I have received a copy of the privacy practices and have been given the opportunity to ask questions, if needed.

Please check all that apply:

I am signing this for _____ myself

_____ a minor under the age of 18

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

SIGNED: _____

DATE: _____

WITNESS: _____

SIGNED: _____

DATE: _____