



NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SIGN INDICATING THAT YOU HAVE READ AND UNDERSTAND THE NOTICE.

Understanding Your Health Record/Information

Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, diagnosis, treatment and a plan for future care of treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, where and why others may access your health information
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of Positive Growth Counseling, LLC the information belongs to you. Privacy Rules (PR) specify that you have a right to:

- Request a restriction on certain uses and disclosures of your information as provided by PR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health records provided for in PR 164.524
- Amend your health record as provided in PR 164.528
- Obtain an accounting of disclosures of your health information as provided in 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

I reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice. We will not disclose your health information without your authorization, except as described in this notice.



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Complaints

If you are concerned that we have violated your privacy rights, or if you are dissatisfied with our privacy policies or procedures, you may file a complaint with our practice by mail as described below and you will not be retaliated against for filing a complaint. You also may file a written complaint with the Office for Civil Rights (OCR), US Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, GA 30303-8909.

Contact

The person to contact for further privacy related information is:
Peggy Rubio, LMHC | Positive Growth Counseling, LLC
161 S. Boyd St.
Winter Garden, FL 34787

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by your mental health counselor will be recorded in your record and used to determine the course of treatment that should work best for you. Your counselor will document in your record his expectations of your treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis.

We will use your health information for regular operations. For example: members of the counseling staff may use information in your health record to assess that care and outcomes in your case and other similar cases. This information will then be used in an effort to continually improve the quality and effectiveness of the counseling services we provide.

Other Uses or Disclosures

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition. If over 18 years of age, this information will only be disclosed with your written permission.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena or court order.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

I, _____, have reviewed the Notice of Privacy Practice, and I have been provided the opportunity to discuss any concerns or questions concerning this information.

Signature of Client _____ Date _____