

## HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health related to health care services.

**Uses and Disclosures of Protected Health Information** Your protected health information may be used and disclosed to others outside of my office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

*Treatment:* I will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, I would disclose your protected health information, as necessary to another health agency or health care provider that provides care to you to ensure that they had necessary information to treat you.

*Payment:* Your protected health information will be used, as needed, to obtain payment for your health care services.

*Healthcare Operations:* I may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law: Child abuse, physical neglect and/or sexual abuse; Adult and Domestic abuse of an incapacitated or vulnerable adult.

*Health Oversight:* Wisconsin Department of Regulation and Licensing conducting an investigation.

*Judicial and Administrative Proceedings:* if you are involved in a court proceeding and a request is made for information about professional services I have provided.

*Serious Threat to Health or Safety:* if I believe there is an imminent risk of harm to yourself or others.

*Worker's Compensation:* it may be necessary to comply with laws relating to worker's compensation or other similar programs.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that I have taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights** Following is a statement of your rights with respect to your protected health information.

*You have the right to inspect and copy your protected health information.* Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

*You have the right to request a restriction of your protected health information.* This means you may ask me not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. I am not required to agree to a restriction that you may request. If I believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to choose another Healthcare Professional.

*You may have the right to request an amendment of your protected health information.* If I deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

*You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.* I reserve the right to change the terms of this notice and will inform you in person of any change. You then have the right to object or withdraw as provided in this notice.

**Complaints** You may complain to Kelly Smerz, PhD, HIPAA Officer, if you believe your privacy rights have been violated. I will not retaliate against you for filing a complaint.

This notice is effective April 14, 2003. I am required by law to maintain the privacy of, and provide individuals with, this

notice.

I have read the information contained within this consent form and HIPAA notice of privacy practices. My signature below indicates my consent to treatment as well as my understanding and agreement to the terms contained within this consent form and HIPAA notice. I have been provided with a copy of the HIPAA form. I have also been provided with an opportunity to discuss any concerns that I may have.

---

Patient Name (Please Print)

---

Patient Signature

---

Dated

---

If applicable, name and signature of parent, guardian, or legal representative  
By signing on this line, I declare that I am the parent, guardian, or legal  
representative of the patient.

---

Dated

---

Witness

---

Dated