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HIPPA NOTICE OF PRIVACY PRACTICES

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 is a **summary** of your rights and our responsibilities regarding your mental health information and its privacy. A full version of this Notice is available online at www.drmeganparis.com or in my office, per your request. If you have any questions, please feel free to ask. This notification takes effect on April 14, 2003 and will remain in force until replaced.*

Protected Health Information (PHI): This refers to information in your health record that could identify you. It is individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care.

How We May Use and Disclose Your Protected Health Information: In accordance with the Health Insurance Portability Accountability Act of 1996 (HIPPA) and its HIPAA Privacy Rule (Rule), we are permitted to use and/or disclose your PHI for the purposes of treatment, the payment for services you receive, for health care operations, appointment reminders, treatment alternatives, health-related benefits and services, individuals involved with your care, worker's compensation, public health risks, as required by law, and to avert a serious threat to health or safety. For most other uses and/or disclosures of your PHI, you will be asked to grant your permission via signed Authorization to Release Information.

Your Rights Regarding Your Protected Health Information (PHI):
Right to Inspect and Copy your medical information.
Right to Request Restrictions or Limitations on information we use or disclose about you for treatment, payment, or health care.
Right to Request an Amendment of information you consider incorrect or incomplete.
Right to an Accounting of Disclosures that we have made of medical information about you.
Right to Receive Confidential Communications as specified by you and also by alternate means or locations.
Right to a Paper or Electronic Copy of this Notice.

Changes to the Notice: We reserve the right to change this Notice and will post a dated copy of it in the office.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with Dr. Paris or with the U. S. Department of Health and Human Services. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have reviewed the Notice of Privacy Practices (above). I am aware that I may review this document online at www.drmeganparis.com and/or request a hardcopy for my records.

____ ______________________________
Client Signature *(electronic signature accepted)* Date

____ ______________________________
Witness Signature Date