

Total Health Concepts, LLC
Virginia Inglese, MA, RD, LCSW
Notice of Privacy Practices
Health Insurance Portability and Accountability Act (HIPPA)

PURPOSE OF THIS NOTICE:

Applicable federal and state laws require your health provider to maintain the privacy of our health and mental health care information. Your record contains personal information about you and your health. The record may identify you and relate to your past, present, or future physical or mental health, referred to as Protected Health Information (PHI).

I am required by law to maintain the privacy of PHI, to provide you notice of my legal duties and privacy practices with respect to PHI, and to abide by the terms of this Notice of Privacy Practices. If the terms of this Notice will change in the future, I will provide you with a copy of the revised Notice at your next appointment or by mail.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

Mental health providers use and disclose PHI for a variety of reasons. Information may be disclosed by electronic or facsimile transmittals, by telephone, or postal service. For most disclosures, I must obtain your consent. If two or more adults are seen together, all must give written permission to release information before any information can be released. However, the law provides that I am permitted to make some disclosures without your consent. Whenever there is a question about the release of PHI, I will err on the side of informed consent and seek your authorization. You may revoke your authorization at any time, which I will honor if legally permitted, except to the extent that I have already acted upon your consent.

Treatment: Your PHI may be used and disclosed for the purpose of providing, coordinating or managing your health care treatment and related services. This includes your provider and related clinical supervisors. In some instances I may disclose non-identifying information about your care with professional consultants to enhance the quality of treatment I provide.

Releases of your PHI to external professionals (such as psychiatrists, school counselors, or lawyers) will only be completed with your specific, signed authorization. If two or more adults are seen together, all must give written permission to release information before any information can be released.

Family, Friends, or Other Involved in Your Care: I will not disclose PHI or any details about your participation in therapy to family or friends without your authorization, except in circumstances required by law.

However, if family members are seen together in therapy, I reserve the right to use professional judgement about whether to maintain individual confidences between family members.

Required by Law: I will only disclose this information without your knowledge if I believe withholding this information increases the risk of harm to you or another. I have the responsibility to disclose your PHI under the following circumstances:

1. To prevent a serious and imminent threat to the health or safety of yourself, another person, or the public. If information is disclosed it will be to the appropriate person or persons reasonably able to prevent or lessen the threat.
2. If I suspect abuse or neglect of a child or elder.
3. If there is an order of the court, such as a subpoena to release your information.

Marketing or Research: I do not release PHI for any external marketing or research activities without your specific authorization.

YOUR RIGHTS REGARDING YOUR PHI:

Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I will consider your request, but am not legally bound to agree to the restriction, especially with regards to disclosures required by law.

Right of Access to Inspect and Copy: You have the right to inspect and copy your PHI by putting the request in writing. However, if two or more adults are seen together, all must give written permission before I can release PHI. If there is compelling evidence that releasing PHI would cause serious harm to you, I reserve the right to restrict access to your PHI. I may charge a reasonable fee for preparing copies of your PHI.

Right to Amend: If you feel that the PHI I have about you is incorrect or incomplete, you may ask me in writing to amend the information, although I am not required to agree to the amendment. Additionally, you have the right to insert a statement into your record; if a response to your statement is inserted, you will be informed of this action, and have the opportunity to review my response.

Right to Accounting and Disclosures: You have the right to request in writing an accounting of the disclosures that I make of your PHI. Your request must state a time period for the disclosures which may not be longer than five years prior to the date of the request. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to a Copy of this Notice: You have the right to receive a copy of this Notice.

COMPLAINTS

If you believe that your privacy rights have been violated or if you are dissatisfied with my privacy policies or procedures, you may file a complaint with the Federal Government. I will not retaliate against you for filing a complaint.

*Federal Government: US Department of Health and Human Services, Office for Civil Rights.
OCRcomplaint@hhs.gov, Region III 150S. Independence Mall West, Suite 372, Public Ledger
Building, Philadelphia, PA 19106-9111, 215-861-441, 800-368-1019, 215-861-4431(Fax)*

Client /Guardian Signature

Date

Effective: 8-1-05