4405 East West Highway, Suite 502
Bethesda, MD 20814
(240)479-4894

Patient Name: **Date:**

NOTICE OF PRIVACY PRACTICES FOR THERAPY AND MINDFULNESS PRACTICES, LLC

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information ("PHI") in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"). This notice involves your privacy rights and describes how information about you may be disclosed and how you can obtain access to your PHI. Please read it carefully.

I am required by law to maintain the privacy and security of your Protected Health Information (PHI). I am required to provide you with a copy of this notice of privacy practices. Additionally I must notify you if a breach occurs. I must notify you of any changes to this notice.

Except for the specific examples listed below, I will only use or disclose your PHI with your written consent. It is your right to revoke consent for release of your information at any time.

There are some instances where I can use or disclose your PHI without your consent.

Uses of your PHI without your consent:

1. For treatment purposes. I can use or disclose your PHI to treat you which could include consulting or coordinating with other mental health providers. My preference is to have written authorization.
2. To obtain payment for your treatment. I can use or disclose your PHI to bill for payment of services. For example I can use and share your health information to bill and get payment from health plans or other entities.
3. For health care operations. I can use and disclose your PHI when conducting health care operations in my practice. Disclosures of PHI can be made in order to run my practice, run our improve your care, and contact you when necessary.

Uses of your PHI which require your authorization:

1. Therapy session notes. I keep records of our therapy sessions. You may request a copy of these notes or you may request that I prepare a summary of your treatment. Please see the Consent to treat form for fees for copying the record. I will never share therapy notes without your written authorization.
2. Marketing purposes. I will not use or disclose your PHI for marketing or business purposes.
3. Sale of PHI. I will not sell your PHI.

Certain uses of PHI which do not require your authorization

1. When disclosure is required by law.
2. If there is suspicion of child abuse or neglect and/or elder abuse or neglect.
3. If there is a threat to safety including reports of threats to the safety of self or others. By my own ethical code, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety, such as suicidal threat.

Therapy & Mindfulness Practices LLC

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4. For health oversight activities including audits and investigations.
5. For judicial proceedings including responding to a subpoena or court order.
6. For law enforcement purposes, including reporting of crimes.
7. For research purposes including mental health studies, although my preference is to have written authorization.
8. For public health . I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority.
9. For worker's compensation purposes. I may provide your PHI in order to comply with worker's compensation laws, although my preference is to have written authorization.
10. For special government functions such as military, national security, and presidential protective services.
11. Appointment reminders and health related services. I may disclose your PHI to remind you of an appointment or to tell you about other treatment alternatives.

Your rights regarding your PHI

1. Right to request limit on uses and discloses of your PHI. You have the right to request that I do not disclose certain PHI for treatment, payment or healthcare operations purposes.
2. Right to request restrictions for out of pocket expenses paid in full. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
3. Right to choose how you receive PHI. You have the right to request that I contact you in a specific way (for example by email versus phone or request that mail be sent to a different address).
4. Right to see and get copies of your PHI. If I receive a written request, I will provide you with a copy of your treatment summary within 30 days of receiving your written request. There is standard fee of $30 for copying and mailing. I may deny your request to inspect and copy in some circumstances.
5. Right to get a list of disclosures I have made. You have a right to request a list of all of the instances where I have disclosed your PHI for purposes other than treatment, payment or healthcare operations.
6. Right to correct or update your PHI. If you believe that there is anything incorrect in your medical record or that there is information missing, you have a right to request that I correct this misinformation. I may say "no" to such a request and require 60 days to process such a request.
7. Right to request a paper or electronic copy of this Notice of Privacy Practices.

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8. Right to choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
9. Right to file a complaint. If you believe your privacy rights may have been violated, you may file a complaint with me. You can also file a complaint by contacting the U.S. Department of Health and Human Services Office for Civil Rights: 200 Independence Ave. S.W., Washington, D.C. 20201 Or calling 1-877-696-6775. Or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. I will not retaliate against you for filing a complaint.

***Changes to the Terms of this Notice:** I may change the terms of this notice. Should a change to this notice occur, I am obligated to notify you of any changes and provide you with an updated Notice of Privacy Practices. Notice must also include: Effective Date of this Notice: September 23,2013. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

ACKNOWLEDGMENT OF THE RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given you. My Notice of Privacy Practices provides information about how I may disclose your protected health information. I encourage you to read it in full. If you have any questions about my Notice of Privacy Practices, please contact me at the address or phone number above.

I acknowledge the receipt of Notice of Privacy Practices of Meghan Renzi, LCSW-C, RYT-200.

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Patient Name Signature Date

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Guardian Name Signature Date

_____

Guardian Name Signature Date

_____

Witness Name Signature Date