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

Client Name: **Date:**

NOTICE OF PRIVACY PRACTICES FOR THERAPY AND MINDFULNESS PRACTICES, LLC

This Notice of Privacy Practices describes how I may use and disclose your Protected Health Information ("PHI") following 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.

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

Except for the specific examples listed below, we will only use or disclose your PHi with your written Consent. It is your right to Revoke Consent for the 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.* We can use or disclose your PHI to treat you, which could include consulting or coordinating with other mental health providers, such as referral sources.
2. *To obtain payment for your treatment.* We can use or disclose your PHI to bill for payment of services. For example, we can use and share your PHI to bill and get payment from health plans or other entities.
3. *For health care operations.* We can use and disclose your PHI when conducting health care operations within Therapy and Mindfulness Practices, LLC. Disclosures of PHI can be made to run the practice, run our improve your care, and contact you when necessary.

Uses of your PHI which require your authorization

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

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Specific uses of PHI which do not require your authorization

1. *When disclosures are required by law.*
2. *If we suspect child abuse or neglect or elder abuse or neglect.*
3. *For safety reasons.* If there is a threat to safety, including reports of threats to harm self or others, we may use and disclose medical information about you when necessary to prevent an immediate, serious threat to your health and safety.
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 our preference is to have written authorization.
8. *For public health*. We 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 to prevent or control disease, injury, or disability, or if directed by a public health authority.
9. *For worker's compensation purposes*. We may provide your PHI to comply with worker's compensation laws, although my preference is to have written authorization.
10. *For special government functions* such as national security.
11. *For appointment reminders and health-related services.* We may disclose your PHI to remind you of an appointment.

Your rights regarding your PHI

1. *The right to request limitations on uses and discloses of your PHI.* You have the right to request that we do not disclose certain PHI for treatment, payment, or healthcare operations purposes.
2. *The right to choose how you receive PHI*. You have the right to request that we contact you in a specific way (for example by email versus phone or request that mail is sent to a different address).
3. *The right to see and get copies of your PHI.* If we receive a written request, we will provide you with a copy of your treatment summary within 30 days of receiving your written request. There is

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a standard fee of $50 for copying and mailing. We may deny your request to inspect and copy in some circumstances.

4. *The right to get a list of disclosures we have made.* You have a right to request a list of all of the instances where we have disclosed your PHI for purposes other than treatment, payment, or healthcare operations.
5. *The 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 we correct this misinformation. We may say "no" to such a request and require 60 days to process such a request.
6. *The right to request a paper or electronic copy* of this Notice of Privacy Practices.
7. *The 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.
8. *The right to file a complaint.* If you believe your privacy rights may have been violated, you may file a complaint with us. 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 call 1-877-696-6775. Visit www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

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

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ACKNOWLEDGMENT OF THE RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I acknowledge the receipt of Notice of Privacy Practices of Therapy and Mindfulness Practices, LLC.

Client Name	Signature	Date
Guardian Name	Signature	Date
Guardian Name	Signature	Date
Staff Witness Name	Signature	Date