

# HIPAA NOTICE OF PRIVACY

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Client Name: \_\_\_\_\_

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.

## **Private Health Information may be used and disclosed in the following circumstances:**

1. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman's compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits by managed care companies.

## **As a client, you have rights to your Private Health Information, including:**

1. The right to review your records or receive a copy of your records by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will receive response or be honored within 15 days.
2. The right to request information of any party that has requested information pertaining to your Private Health Information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

## **As a private practioner, I have the responsibility to:**

1. Make each client aware of the Privacy Notice.
2. At any time make the necessary changes to the Privacy Notice that are required by law.

If you as the client feel your privacy has been violated, you have the right to contact The U.S. Department of Health & Human Services Office of Civil Rights at [www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/).

I have reviewed and understand this notice.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

