Confidentiality - RESTORE THERAPY COLLECTIVE

** indicates a required field*

Your confidentiality is very important to us.

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.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The purpose of this notice is to let you know how and to whom your private health information (PHI) can be disclosed. PHI is any information created by me in the course of your treatment that can identify you.

HIPAA allows for the disclosure of you PHI without your consent for the following reasons:
to coordinate with other professionals
to bill and collect payment for my services
to leave message on your answering machine
to comply with health oversight agencies (i.e. insurance company audits)
(However, because I believe so strongly in guarding the confidentiality of our work, along with the ethical guideline of my profession and state law, I will continue my usual policy of attempting to secure your permission for any disclosure except for the reasons stated below as required by law.)

State of Michigan law requires that I disclose you PHI without your consent if:
you are a danger to yourself or others
you are unable to meet your basic physical needs
you tell me of a serious and imminent threat of violence by you against another
I have a reasonable suspicion of child abuse or neglect on your part

CLIENT RIGHTS

HIPAA also requires that I clearly outline your rights regarding your PHI.
to see and/or get copies of your PHI within 30 days of your written request
to limit the use and disclosure of your PHI (see next page)
to request that I confidentially communicate with you in a certain way
to get a list of disclosures of your PHI that I have made
to ask me to update or modify your PHI if you believe your record is incorrect
to request of copy of the notice at any time

Ask me about any of these rights and I will inform you of the outlined HIPAA procedures to exercise these rights. This detailed information will also explain the possible denial of your requests and the course of action that you can take at that time. Please feel free to talk with me about specific questions or concerns.

QUESTIONS AND COMPLAINTS

HIPAA requires that you receive this address if you believe that I have violated your privacy rights:
Secretary of the Dept of Health and Human Services
200 Independence Ave SW, Washington DC 20201

RECEIPT AND ACKNOWLEDGEMENT

* **I acknowledge receipt of Restore Therapy Collective Notice of Privacy Practices (HIPAA).** _____

I consent to sharing information provided here.

RESTRICT DISCLOSURE

I exercise my HIPAA right to restrict disclosure of my PHI by Restore Therapy Collective. I understand that Restore Therapy Collective will attempt to secure my permission for any specific disclosures except those legally required to make (see above). _____

I consent to sharing information provided here.