Notice of Privacy Practices (HIPPA)

Allison Milana-Trinka, LMHC, PLLC

799 Deer Park Ave.

North Babylon, NY 11704

516-650-9364

Notice of Privacy Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This Notice of Privacy Practices describes how I protect your personal health information, tells how I may use and disclose your clinical information, and explains certain rights you have regarding this information. I am providing you with this notice in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and will comply with the terms as stated. I will obey the rules of this notice as long as it is in effect, and notify you of any changes. You may request a copy at any time.

How I Use and Disclose Your Personal Health Information

I protect your personal health information from inappropriate use and disclosure. Your information is obtained in the course of providing services to you and is related to your medical records, psychotherapy visits, and payment information. It is likely to include your history, reasons you came for psychotherapy, diagnoses, progress notes I make (but not psychotherapy notes I may choose to make (recording dreams, fantasies, theme, etc. for my own use), records I get from others who worked or work with you or evaluate you, and billing and insurance information. I will not disclose any personal health information without your written authorization, unless such disclosure is permitted or required by law. The law permits me to disclose your health information without a signed authorization from you when I am using it to provide you with your mental health care. For example, I use your clinical information to plan your care, to decide how well your psychotherapy is working, when I talk with other professionals who are also treating you, for teaching and training other psychotherapy professionals, and for mental health research.

How your protected health information can be used and shared

When your information is read by me, in the law that is called “use.” If the information is shared with or sent to others outside this office, in the law that is called “disclosure.” Except in some special circumstances, when I use your PHI here or disclose it to others, I share only the minimum necessary for those other people to do their jobs. The law gives you rights to know about your PHI, how it is used and to have say in how it is disclosed (shared), and so I will tell you more about what I do with your information.

Uses and disclosures of PHI in health care with your consent

After you have read this Notice you will be asked to sign a separate consent form to allow me to use and share your personal health information. In almost all cases, I intend to use your personal health information here, or to share your personal health information with other people or organizations to provide treatment to you, to arrange for payment for our services, or some other business functions called health care operations. Generally, I may use or disclose your PHI for three purposes: treatment, obtaining payment, and what are called health care operations.

Treatment and Care Management

I need information about you to provide care to you. You agree to let me collect the information and to use it and share it to care for you properly. Therefore you must sign the Consent form before I begin to treat you, because if you do not agree and consent I cannot treat you. Health information about you may be used or disclosed to assist treatment by health care providers. This would include treatment provided to you by me, and coordinating your care with other providers such as physicians, hospitals, or nursing homes. For example, I may refer you to other health-care or medical professionals or consultants for services I cannot provide. When I do this I need to tell them some things about you and your conditions. I will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, I can also share your health information with them.

Payment

I may use your information to bill you, your insurance, or others so I can be paid for the treatments I provide to you. I may contact your insurance company to check on exactly what your insurance covers. I may have to tell

them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things.

To individuals involved in your care. Your health information may be disclosed to a family member, other relative or close personal friend assisting you in receiving or obtaining payment for health care services. I will disclose your health information to these individuals only if you tell me to do this or if I can reasonably infer that you do not object. I may also disclose your health information to disaster relief organizations such as the Red Cross to assist your family members or friends in locating you or learning about your general condition in the event of a disaster.

Appointments, Information or Services. I may contact you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you. I may also use or disclose your health information for judicial or administrative proceedings, for specialized government functions, for workers' compensation or similar purposes. If you want me to call or write to you only at your home or your work or prefer some other way to reach you, I can usually arrange that. Just tell me.

Business Associates. There are some tasks I may hire other businesses to do for me. Examples include a copy service used to make copies of your health records, and a bookkeeper. These business associates need to receive some of your health information to do their jobs properly. To protect your privacy, they agree in their contract with me to safeguard your information.

Obtaining Your Authorization for Other Uses and Disclosures

I will not use or disclose your health information for any purpose not specified in this Notice of Privacy Practices unless I obtain your express written authorization to do so. If you give us your authorization, you may revoke it at any time in writing, in which case we will no longer use or disclose your health information for the purpose you authorized, except to the extent we have relied on your authorization in providing benefits. I may refuse to enroll or continue to provide benefits to you if you decide not to sign an authorization form.

Your Rights Regarding Your Health Information

Right to Inspect and Copy. You have the right to inspect or request a copy of personal health information about you that I maintain and that I may use in making decisions about your care. Your request should describe the information you want to review. In limited circumstances, you may not be able to review or copy certain information. These include psychotherapy notes, or information collected in anticipation of a claim or legal proceeding. If I determine that reviewing your records may cause substantial and identifiable harm to you or others or would have a detrimental effect on your treatment, on our professional relationship, or on your relationship with parents, guardians, spouses, or children, I may deny access to your records. A patient over the age of twelve may be notified of any request by a qualified person to review his or her record, and if the patient objects to the disclosure, I may deny the request for access. I may charge you a reasonable fee for copying.

Right to Request Amendments. You have the right to request changes to any health information I maintain about you if you state a reason why this information is incorrect or incomplete. I may not agree to make the changes you request. If I do not believe the changes you requested are appropriate, I will notify you in writing how you can have your objection to my decision included in my records.

Right to an Accounting of Disclosures. You have the right to receive a list of disclosures of your health information that have been made by me. The list will not include disclosures made for certain types of purposes, such as disclosures for treatment, payment or health care operations or disclosures you authorized in writing. Your request should specify the time period for which you want this list, which can be no longer than six years. The first time you ask for a list of disclosures in any 12-month period, I will provide it for free. If you request additional lists during a 12-month period, I may charge you a fee to cover our costs in providing the additional lists.

Right to Request Restrictions. You have the right to request restrictions on the ways in which I use and disclose your health information for treatment, payment and health care operations, or disclose this information to disaster relief organizations or individuals who are involved in your care. I may not agree to the restrictions you request.

Right to Request Confidential Communications. You have the right to ask me to send health information to you in a different way or at a different location if you believe that you may be endangered by my ordinary form of communication. You must state in your request that you believe you will be endangered by my ordinary form of communication but you do not have to explain why you believe this is the case. You may ask me to send health information to you in a different way or at a different location. Your request should also specify where and/or how I should contact you. We will accommodate all reasonable requests.

Right to Paper Copy of Notice. You have the right to receive a paper copy of this Notice of Privacy Practices at any time. You may receive a paper copy even if you have previously requested to receive this Notice electronically.

Uses and disclosures where you have an opportunity to object

If I want to use your information for any purpose besides those described above, I need your permission on an **authorization form**. If you do authorize me to use or disclose your health information, you can cancel that permission, in writing, at any time. After that time I will not use or disclose your information for the purposes that we agreed to. Of course, I cannot take back any information that I had already disclosed with your permission or that I had used in my office. Occasionally, with your permission and if we determine this to be helpful to your care, I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about whom you want me to tell what information about your condition or treatment. You can tell me what you want, and I will honor your wishes, as long as it is not against the law. If it is an emergency, so that we cannot ask if you disagree, I can share information if I believe that this is what you would want and if I believe it will help you if I do share it. If I do share information in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

If you have questions or problems

If you need more information or have questions about the privacy practices described above, please speak to me. If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. I promise that I will not in any way limit your care or take any actions against you if you complain.

PATIENT ACKNOWLEDGMENT

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.