Paula Hofmann, MA, LPCC
Licensed Professional Clinical Counselor

Notice of Privacy Practice

This notice describes how the medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
As your professional counselor, I care about your privacy and strive to protect the confidentiality of your medical information in my practice. Federal legislation requires this notice of privacy practices. You have the right to confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information.

Who Will Follow This Notice
Any health care professional authorized to enter information into your medical records, all employees, staff and other personnel at the practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share information with each other for treatment purposes of health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish this task will be shared.

How We May Use and Disclose Medical Information About You
The following categories describe different ways that I may use and disclose medical information without your specific request or authorization. Examples are provided fro each category of uses or disclosures. Not every possible use or disclosure in a category has been listed.

For Treatment. We may use medical information about you to provide you with medical treatment services. Example: In treating you for a specific condition we may need to know if you have other conditions that may affect your treatment.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company, or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to ensure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization
- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or a law enforcement official
- As required by the US Food and Drug Adminstration (FDA)

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and disclosures of Protected Health Information Requiring Written Authorization
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to maintain records of the care we have provided you.

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ACKNOWLEDGMENT OF RECEIPT OF DISCLOSURE STATEMENT, NOTICES, CONSENT, RIGHTS AND RESPONSIBILITIES

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A CURRENT COPY OF THIS PRACTICE'S NOTICE OF PRIVACY ACT, MY CLIENT RIGHTS AND RESPONSIBILITIES, PROFESSIONAL DISCLOSURE STATEMENT, AND CONSENT TO TREATMENT.

_____ _____
Signature Date

_____
Print Name

_____
If signed by patient representative, please indicate the relationship to the patient.

CONSENT

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies or third parties, and for health care operations such as quality reviews.

I have been informed that I may review this practice's Notice of Privacy Act before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at this practice.

I understand that I have a right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction(s), they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for any information already used or disclosed.

_____
Initials

ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A CURRENT COPY OF MY CLIENT RIGHTS AND RESPONSIBILITIES , NOTICE OF PRIVACY ACT, PROFESSIONAL DISCLOSURE STATEMENT, AND CONSENT TO TREATMENT.

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