ERIN HOLT, M.Ed., LPC

1212 N. Center Street

Bonham, Texas 75418

469-964-2297

HIPPA Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL/COUNSELING INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose your health information.

We may use and disclose your psychological/counseling records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Therefore, information may be shared by other healthcare providers who are treating you for the same condition.

Payment means such activities as obtaining reimbursement for services, confirmation coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request; except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information:

 The right of restrictions on certain uses and disclosures of protected health information which includes any and all persons with the following exceptions:

- Legal parents or guardians of minor patients
- Ordered disclosure from a court of law
- In cases of child or elder abuse

- The right to reasonable requests to receive confidential communications of protected health

  information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information in the event the original information is inaccurate.
- The right to receive an accounting of disclosures of unprotected health information.
- The right to obtain a paper copy of this Notice from us upon request.

We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This Notice is effective _____20_____, and we are required to abide by the terms
of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice or Privacy Practice, and to make the new Notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this Notice, or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I AGREE TO THE ABOVE STATED CONDITIONS OF "HIPAA" AS THEY APPLY TO ME AND Erin Holt, LPC. A COPY OF THESE PROVISIONS HAS BEEN MADE AVAILABLE TO ME.

_____ Signature and Date

_____ Printed Name