TRUE SELF COUNSELING SERVICES

HIPAA Privacy Notice and New Patient Consent to the Use and Disclosure of Health Information

At ***True Self Counseling Services***, we are committed to treating and using health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights are they relate to your Protected Health Information. This notice became effective June 1, 2005, and applies to all Protected Health Information as defined by Federal Regulations. Each time you visit ***True Self Counseling Services***, a record of your visit is made. This medical record typically contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information serves as:

- Basis for planning care and treatment.
- Means of communicating among the many health professionals who contribute to your care.
- Legal document describing the care you receive.
- Means by which you or a third party payer (ie., insurance) can verify that services billed were actually provided.
- Source of information for public health officials charged with improving the health of the state and the Nation, as required by law (ie., reporting child abuse and neglect or reporting domestic violence).
- Basis for disclosing your child's health information to a law enforcement official, for purposes such as identifying or locating an individual, in complying with a court order or subpoena, etc.
- Source for public safety. We may disclose your child's health information to appropriate persons in order to prevent or lessen a serious threat to health or safety of a particular person, or the general public.
- Tool in educating health professionals, source of data for medical research, and tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Although your health record is the physical property of ***True Self Counseling Services***, the information belongs to you. You have the right to:

- Review the Consent before signing it.
- Object to the use of your health information for directory purposes.
- Request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or health care operations.
- Request a restriction on certain uses and disclosures of your information, as provided by 45 CFR 164.522.

True Self Counseling Services is required to:

- Maintain the privacy of your health information.
- Provide you with a copy of this Notice as to your legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we are unable to agree to a request restriction.
- Accommodate reasonable requests you may have to communicate health information by alternate means or at alternative locations.

We reserve the right to change our practice and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice, provided those changes affect your health information, to you at the address you have supplied us, or if agreed, via email. We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization, according to the procedures included in the Authorization.

I, _____ ***(print name of patient)*** understand the content of this Notice. Further, I permit a copy of this acknowledgement to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefit apply. I understand that as a part of ***True Self Counseling Services***' treatment, payment, or healthcare operations, it might become necessary to disclose my protected health information to another entity (ie., insurance, emergency, etc…) and I consent to such disclosures for these permitted uses, including via fax and e-mail only to appropriate parties.

I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice.

Name of patient: _____ **Date:** _____

Patient Signature: _____

If refused, reason for refusal: _____

Restrictions noted: _____

10637 NORTH KENDALL DRIVE, SUITE 7F
MIAMI, FL 33176

(786) 393-2236
INFO@TRUESELFCOUNSELINGSERVICES.COM