

## Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

***The undersigned acknowledges receipt of a copy of the currently effective HIPAA Notice of Privacy Practices. A copy of this signed and dated acknowledgment shall be as effective as the original.***

\_\_\_\_\_  
Signature of Client (or Legal Guardian if client under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client (or Legal Guardian of client)  
(If Legal guardian, indicate relationship/authority to client)

***Thank you. If you have any questions about this form, or the attached notice, please contact **John Cutrone, LMHC, CAS.*****

**Effective Date: 09/01/2013**

## **HIPAA NOTICE OF PRIVACY PRACTICES**

**I am required by law to maintain the privacy of Personal Health Information. I am required to provide this Notice of Privacy Practices to you by the privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").**

**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.**

**If you have any questions about this notice, please contact John Cutrone, LMHC, CAS.**

### **MY OBLIGATIONS:**

**I am required by law to:**

- **Maintain the privacy of protected health information**
- **Give you this notice of my legal duties and privacy practices regarding health information about you**
- **Follow the terms of my notice that is currently in effect**

### **HOW I MAY USE AND DISCLOSE HEALTH INFORMATION:**

The following describes the ways I may use and disclose Protected Health Information that identifies you ("PHI"). Except for the purposes described below, I will use and disclose PHI **only with your written authorization to obtain and/or release information. You may revoke such authorization at any time by requesting this to me in writing.**

**For Treatment.** I may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, I may disclose PHI to other therapists, psychiatrists, doctors, or other health care providers, who are involved in your medical care and need the information to provide you with medical care.

**For Payment.** I may use and disclose PHI so that I bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, I may give your health plan information about you so that they will pay for your treatment.

**For Health Care Operations.** I may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of my clients receive quality care, and to operate and manage my office. Example of health care operations include: quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. I also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders.** I may use and disclose PHI to contact you to remind you that you have an appointment with us.

**Email Communication.** With your expressed and written permission, I may use and disclose PHI to communicate with you via email regarding appointments, general communication, or related to your treatment with me.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, I may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. I also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Business Associates.** I may have Business Associates such as billing services, bookkeepers, accountants, etc. who may have access to your PHI when they are preparing my routine financial statements, or entering any payments from you, or insurance companies.

## **SPECIAL SITUATIONS:**

***As Required by Law.*** I will disclose PHI when required to do so by international, federal, state or local law. **These disclosures do not require prior written consent or authorization by you.**

***To Avert a Serious Threat to Health or Safety.*** I may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

***Military and Veterans.*** If you are a member of the armed forces, I may release PHI as required by military command authorities. I also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

***Workers' Compensation.*** I may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

***Public Health Risks.*** I may disclose PHI for public health activities. These activities generally include: disclosures to prevent or control disease, injury or disability; report births and deaths; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

***Abuse or Neglect.*** If I have reasonable suspicion to believe that any minor (under 18 years old) has been the victim of abuse or neglect, or exposed to domestic violence, the law requires that I file a report to the appropriate government agency, usually the Department of Children and Families.

If I have reason to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable or disabled adult has occurred, the law requires that I file a report with the appropriate government agency.

***Duty to Warn.*** If I have reason to believe that there is an imminent danger to the health or safety of the client or any other individual, I may be legally required to take protective action(s). These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the client, or contacting family members or others who can help provide protection.

***Health Oversight Activities.*** I may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

***Data Breach Notification Purposes.*** I may use or disclose your Protected PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

***Lawsuits and Disputes.*** If you are involved in a lawsuit or a dispute, I may disclose PHI in response to a court or administrative order. I also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

***Law Enforcement.*** I may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, I am unable to obtain the person's agreement; (4) about a death I believe may be the result of criminal conduct; (5) about criminal conduct on my premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

***Coroners, Medical Examiners and Funeral Directors.*** I may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. I also may release PHI to funeral directors as necessary for their duties.

***National Security and Intelligence Activities.*** I may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

***Protective Services for the President and Others.*** I may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

**YOUR WRITTEN AUTHORIZATION IS REQUIRED  
FOR ALL OTHER USES AND DISCLOSURES**

**USES AND DISCLOSURES THAT REQUIRE US  
TO GIVE YOU AN OPPORTUNITY TO OBJECT  
AND OPT**

***Individuals Involved in Your Care or Payment for Your Care.*** Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, I may disclose such information as necessary if I determine that it is in your best interest based on my professional judgment.

***Disaster Relief.*** I may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. I will provide you with an opportunity to agree or object to such a disclosure whenever I practically can do so.

**YOUR RIGHTS:**

You have the following rights regarding PHI I have about you:

***Right to Inspect and Copy.*** You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this PHI, you must make your request, in writing, to **John Cutrone, LMHC, CAS**. I have up to 30 days to make your PHI available to you and I may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. I may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. I may deny your request in certain limited circumstances. If I do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and I will comply with the outcome of the review.

***Right to an Electronic Copy of Electronic Medical Records.*** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to

request that an electronic copy of your record be given to you or transmitted to another individual or entity. I will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either my standard electronic format or if you do not want this form or format, a readable hard copy form. I may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

***Right to Get Notice of a Breach.*** You have the right to be notified upon a breach of any of your unsecured PHI.

***Right to Amend.*** If you feel that PHI I have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for my office. I may deny your request. To request an amendment, you must make your request, in writing, to **John Cutrone, LMHC, CAS**.

***Right to an Accounting of Disclosures.*** You have the right to request a list of certain disclosures I made of PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to **John Cutrone, LMHC, CAS**.

***Right to Request Restrictions.*** You have the right to request a restriction or limitation on the PHI I use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI I disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that I not share information about a particular diagnosis or treatment with your spouse.

To request a restriction, you must make your request, in writing, to **John Cutrone, LMHC, CAS**. I am not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.

**Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that I not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I will honor that request.

***Right to Request Confidential Communications.***

You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to **John Cutrone, LMHC, CAS**. Your request must specify how or where you wish to be contacted. I will accommodate reasonable requests.

***Right to a Paper Copy of This Notice.*** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at my web site, [www.naguiatLMHC.com](http://www.naguiatLMHC.com). To obtain a paper copy of this notice, inquire with **John Cutrone, LMHC, CAS**.

**CHANGES TO THIS NOTICE:**

I reserve the right to change this notice and make the new notice apply to PHI I already have as well as any information I receive in the future. I will post a copy of my current notice at my office. The notice will contain the effective date on the first page, in the top right-hand corner.

**COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with my office, contact **John Cutrone, LMHC, CAS**. All complaints must be made in writing. **You will not be penalized for filing a complaint.**