Upstate Pediatric Speech Therapy Services
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Office 864-438-0990 Fax 864-478-8383
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NOTICE OF PRIVACY PRACTICES

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.

PHI: Protected Health Information; Purpose of this Notice:

We respect the privacy of your PHI and understand the importance of keeping it safe and secure. This Notice describes my privacy practices and how I protect the confidentiality of your PHI. I am obligated to maintain the privacy of your PHI by implementing reasonable and appropriate safeguards.

Types of Use and Disclosure of PHI that I may make without your authorization:

For treatment: I may use PHI about you to provide you with medical treatment or services. I may disclose PHI about you to doctors, teachers, administrators or office staff.

For payment: I may use and disclose PHI about you so that treatment and services may be filed with and payment collected from insurance companies.

Revocation of Consent: You may revoke your consent at any time by giving me written notice.
If you revoke your consent, I will not be permitted to use or disclose information for the purposes of treatment or payment.

Authorizations: All other uses/disclosures of your PHI must be made with written authorization.

Your Rights Regarding your PHI

Access to your PHI: You have the right to review and receive a copy of the PHI that I maintain.
You will always receive a copy of the report and treatment plan that is generated.

Right to Amend Your PHI: You have the right to request amendments to your PHI. If you wish to have your PHI corrected/updated, please write and tell what you want changed and why.

Right to Receive an Accounting of Disclosures of your PHI: You have a right to request an accounting of certain disclosures that I make of your PHI.

Right to Place Restrictions on PHI: You have the right to request restrictions on how I use and disclose your PHI for treatment and payment.

Right to Receive Confidential Communications: You may restrict and/or direct communication.

Right to Receive a Copy: You have the right to request and receive a paper copy of this notice.

Right to Complain: I must follow the privacy practices set forth in this notice while in effect. If you have any questions, please direct inquiries to the address at the top.

Rights Reserved: I will use and disclose your PHI to the fullest extent authorized by law. You may request any updates to this Notice at any time.

My DUTIES UNDER HIPAA:

1) Maintain the privacy of your PHI; **2)** Reserve the right to change the terms of this Notice at any time; **3)** Abide by the terms of this Notice. The terms of this Notice will remain in effect indefinitely unless you are notified of modifications.

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Name of Patient Patient DOB

_____ _____

Signature of Parent/Legal Guardian Date