Alliance for Eating Disorders Awareness Psychological Services
1649 Forum Place, Suite 10
West Palm Beach, Florida 33401

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Information Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by me in any form, whether electronically, on paper, or orally are kept confidential. As required by HIPAA, I have prepared this explanation of how I am required to maintain, use, and disclose your private health information in accordance with federal and state law.

My Legal Duty:

I am required by applicable federal and state law to maintain the privacy of protected health information, and must inform you of my privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request. I am required to abide by the terms of the Notice of Privacy Practices that is most current. I reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that I maintain. You may request a copy of the revised Notice at any time. As Privacy Officer, I can answer your questions about my privacy practices and also will take your complaints and can give you information about how to file a complaint.

Use and Disclosure of Health Information:

I use and disclose your protected health information for treatment, payment, and healthcare operations. First, I may use information in your record to provide treatment to you. I may disclose information in your record to help you get health care services from another provider, a hospital, etc.. Second, I may use or disclose information from your record to obtain payment for the services you receive. Third, I may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers.

Your Rights:

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, I do not have to agree to these restrictions. You have a right to receive confidential communications from me. For example, if you want to receive bills and other information at an alternative address, please notify me. You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing. If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing. You have the right to request an accounting of certain disclosures made by me. You have the right to complain to me about my privacy practices. You have the right to complain to the Secretary of the Department of Health and Human Services about my privacy practices. You will not face retaliation from me for making complaints. Except as described in this Notice, I may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by me before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

Disclosure of Your Protected Health Information:
I may use or disclose your protected health information when I am required to do so by federal and/or state law. For example, state law requires me to report suspected child abuse or neglect. I must disclose information to the Department of Health and Human Services, if requested, to prove that I am complying with regulations that safeguard your health information. Also, I must disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Communications between a psychotherapist and client in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, I may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others. There are certain situations where I am allowed to disclose information from your record without your permission. I may disclose information from your record to a law enforcement official if certain criteria are met. I may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President. I may contact you to provide appointment reminders as a courtesy.

Questions and Complaints:
If you have any further questions and/or concerns about my privacy practices, please contact me. If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me. You also may submit a written complaint to the U.S. Department of Health and Human Services. I support your right to the privacy of your health information. I will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

Contact Information:

Alliance for Eating Disorders Awareness
Services Psychological Services
1649 Forum Place, Suite 10
(561) 841-0900

U.S. Dept. of Health and Human
Office of Civil Rights
200 Independence Ave., SW
Washington, DC 20201
(877) 696-6775

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: ________________________

Patient: ____
Signature of Patient or Personal Representative

Relationship of Personal Representative to the Patient: ______________________________

Witness: ____