Coral Springs Annex LLC

Notice of Privacy Practices

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

This notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information (PHI), with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your PHI. You have the right to approve or refuse the release of specific information outside of our office except when the release is required by law or regulation.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgement of receipt of this notice by signing below. Our intent is to make you aware of the possible use and disclosure of your PHI and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your PHI for treatment, payment, and health care operations when necessary.

By signing below, I acknowledge that I have received a copy of this Notice of Privacy Practices.

Signature _____

Date _____

CLIENT STATEMENT OF UNDERSTANDING

I understand that confidentiality of records and information about me will be held in accordance with State and Federal laws regarding confidentiality. I understand that by law, confidential information may be provided under the following circumstances:

1. If I give written permission requesting release of information.
2. If a court orders the release of my records.
3. If I raise my mental status or competency in legal proceedings.
4. It there is reason to believe that I may be a danger to myself or to others.
5. If there is evidence or reason to suspect abuse or neglect of a child or of an incompetent or disabled person.

I have read and understand the above.

Signature _____ Date _____

SIGNATURE ON FILE

I authorize release of any payment and medical information necessary to process claims and related claims. Please accept a photocopy of this authorization as if it were an original authorization. My signature below serves as a signature on file.

Signature _____ Date _____