SARA HOPKINS, LCSW

2040 Winter Springs Blvd
Oviedo, Florida 32765

Tel. 407-588-7880

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED BY ME, OR MY STAFF AND HOW TO ACCESS THIS INFORMATION.

Effective date of this notice: April 14, 2003

PLEASE REVIEW THIS NOTICE CAREFULLY.

MY PLEDGE REGARDING YOUR HEALTH INFORMATION:
I understand and appreciate that information about you and your healthcare is personal. I am committed to protecting the privacy of both you, the client and your healthcare information.

HOW I MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

FOR TREATMENT: I may use health information about you to provide you with treatment and services. I may disclose your information to doctors, hospitals or other mental healthcare providers to whom I may refer you for consultation.
FOR PAYMENT: I may use and disclose health information so that the treatment and services you receive from me may be billed to and payment collected from you, an insurance company, or a third party. In some instances I may need to tell your health plan about a treatment that you are going to receive in order to obtain approval or to determine whether your plan will cover the treatment.
FOR HEALTHCARE OPERATIONS: I may use and disclose mental health information for operations of my mental healthcare practice. These uses and disclosures are necessary to run my practice and ensure that all clients receive quality care. For example, I may use information to review treatment and services and to evaluate the performance of my staff in caring for you. I may also combine information about many patients to decide what additional services I should offer, which are not needed, etc.
APPOINTMENT REMINDERS: I may use and disclose information to contact you as a reminder of an appointment. Please let the office know if you do not wish to have us contact you concerning your appointment, or if you wish to use a different telephone number or address for contact purposes.
AS REQUIRED BY LAW: I will disclose information about you when required to do so by federal, state, or local law enforcement agencies:
FOR ACTIVE MEMBERS OR VETRANS OF THE U.S. ARMED SERVICES: I may release information about you as required by military command authorities or the Dept. of Veterans Affairs when applicable.
WORKER'S COMPENSATION: I may release information about you for worker's compensation or similar programs that provide benefits for work related injuries or illnesses.
PUBLIC HEALTH RISKS: I may disclose health information about you for public health activities.
These generally include.

- Prevention or control of disease, injury or disability;
- Reporting births or death;
- Reporting child abuse and or neglect;
- Reporting reactions to medications or problems with products;
- Notifications to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- Notification to the appropriate government authority if I believe a client has been the victim of abuse, neglect, or domestic violence. I will only make this disclosure if you agree or when required by law.

HEALTH OVERSIGHT ACTIVITIES: I may disclose health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, inspections, and licensure. This is necessary for the government to monitor the health care system, government sponsored programs, and compliance with civil rights laws.

LAWSUITS AND DISPUTES: If you are involved in a lawsuit or dispute, I may disclose information about you in response to an order issued by a court or administrative tribunal. I may also disclose information in response to subpoena, discovery request, or other lawful process by someone involved in the dispute, but only after efforts have been made to tell you about the request and you have the time to obtain an order protecting the information requested.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding your private and protected health information maintained by me.

RIGHT TO INSPECT AND COPY: You have certain rights to inspect and copy health information that may be used to make a decision about your care. Usually, this includes health and billing records but **this does not include psychotherapy notes**. To inspect and copy information, you must submit your request to me in writing. I may charge a fee for the costs associated with your request.

RIGHT TO AMEND: If you feel the health information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as I maintain the information. Your request must be made in writing.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request a listing of any disclosures of your health information that I have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described, or pursuant to an authorization you have provided. To request this listing you must submit your request to me in writing.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the health information I use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the information I disclose about you to someone who is involved in your care or the payment of your care. For example, you may ask that access to your information be denied to a member of my staff whom you know personally. While I will try to accommodate your request for restrictions, I am not required by the law to do so. To request a restriction you must tell me, in writing, what information you want to limit and to whom you want the limits to apply.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right to obtain a paper copy of this notice at any time upon request.

CHANGES TO THIS NOTICE

I reserve the right to change this notice. I reserve the right to make the revised or changed notice effective for the information I already have about you as well as any information I receive in the future. I will post a copy of the current notice in the Patient Waiting Area. The notice will contain the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to my practice will be made only with your written permission. If you provide this office permission to use or disclose your health information you may revoke that permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose health information about you for reasons that you provide in your written authorization. You must have the understanding that this office can not take back any disclosures already made with your permission prior to the revocation.

Adopted 04/14/03
Health Insurance Portability and Accounting Act, 1996
Last Modified 08/25/03

SARA HOPKINS, LCSW

505 N PARK AVE.
SUITE 201
WINTER PARK, FL 32789
Tel. 407-588-7880

I, _____have received a copy of the Privacy Practices adhered to by Sara Hopkins, LCSW. I further understand that it is my right as a client to receive an additional copy of the Privacy Practices upon request. I acknowledge receipt by placing my signature below.

_____ _____

(Clients Name) (Date)