Mindkind Counseling Services LLC
Danica Rozario LPC, NCC
424 Baldwin Avenue, Jersey City, NJ 07306 II 908-858-2470 II www.mindkindcounseling.com

# Notice of HIPAA Privacy Practices

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.

## I. My Responsibility

The confidentiality of your personal health information (PHI) is very important to me. Your health information includes records that I create and obtain when I provide you care. It also includes bills, insurance claims, or other payment information that I maintain related to your care. I am required to maintain the privacy of your health information as required by law, provide you with this Notice of my duties and privacy practices regarding the health information about you that I collect and maintain, and follow the terms of my Notice currently in effect.

I may use or disclose PHI without your consent in the following circumstances:

- If I have reason to believe you are a danger to yourself, I must contact your emergency contact person and/or psychiatric emergency services in order to ensure your safety.

- If I have reason to believe you intend to harm a readily identifiable victim, I must take steps to warn and protect that person. This may entail contacting local police departments, your emergency contact person and/or psychiatric emergency services in order to ensure their safety.

- If I have reasonable cause to believe that a child is being subject to abuse, I must report this to the NJ Division of Youth and Family Services.

- If I believe that a vulnerable adult is being subject to abuse, I must contact Adult Protective Services.

## II. Contact Information

After reviewing this Notice, if you need further information or want to contact me for any reason regarding the handling of your health information, I can be reached at 908-858-2470.
In case of an emergency, I authorize Danica Rozario LPC, NCC to contact the following person(s):
Name_____ Relationship_____ Phone: (_____)_____
Name_____ Relationship_____ Phone: (_____)_____

## III. Uses and Disclosures of Information

Under federal law, I am permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. I may share the minimum amount of personal health information necessary for business associates performing services on my behalf.

## IV. Any Other Use or Disclosure

Before using or disclosing your personal health information for any other purpose not identified above, I will obtain your written authorization. Unless action has already been taken in compliance with the authorization, you have the right to revoke such authorization by submitting your written request to me.

## V. Your Health Information Rights

Request that I restrict certain uses and disclosures of your health information; I am not, however, required to agree to a requested restriction.

Request that I communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. Box. I will accommodate reasonable requests for such confidential communications.

Request to review, or to receive a copy of, the health information about you that is maintained in my files and the files of my business associates. I reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. If I am unable to satisfy your request, I will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.

Request that I amend the health information about you that is maintained in my files and the files of my business associates. Your request must explain why you believe my records require amendment. If I am unable to satisfy your request, I will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement disagreeing with the decision. This statement will be added to your records.

Request a list of my disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. I will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, I may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested. I will be unable to provide you an accounting for any disclosures made before Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit a written request to me. If you have questions about your rights, please speak with me, available by phone or email during normal office hours.

VI. To Request Information or File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to me. You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-(800) 368-1019; or by sending an email to OCRprivacy@hhs.gov. I cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint.

VII. Revisions to this Notice

I reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that I maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, my legal duties, or other privacy practices described in the Notice, I will promptly distribute the revised Notice, post it in my office, and make copies available to my patients and others.

Client Acknowledgment

Client name_____Date of birth _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Danica Rozario LPC, NCC. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

Signature_____ Date_____

Relationship to client (if signed by authorized representative)

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