

Notice of Privacy Practices – HIPPA

Please read this notice carefully because it is about your privacy regarding your healthcare information. I take your privacy seriously and am required by the laws of the United States and the state of North Carolina to keep your health information private. This notice is about how your healthcare information may be used and/or disclosed and how you can obtain a copy of your healthcare information. I am required by the laws of the United States and the state of North Carolina to give you notice of my privacy practices and to abide by them.

This notice takes effect on January 1, 2018 and will be effective until I replace it. I am legally allowed to change these practices as long as they are in accordance with what is permitted and required by law. If I change these practices at any time, I will amend this notice and give copies to all active clients.

Please ask any questions you have after reading this notice. I will make a copy of this notice for you at no charge for your personal records.

Your Rights Regarding Your Healthcare Information

1. You have the right to a copy of this notice.
2. With limited exception, you have a right to access your healthcare information that I use and maintain for my records. If you would like a copy of your healthcare information, please submit a written request and I will provide you with one copy of your healthcare information free of charge. Any additional copies will require a fee of \$.25 a page.
3. Upon inspection of your healthcare information, if you feel as though your information is incorrect or incomplete, you have the right to request me to amend your information, however, I am not required to agree to the amendment.
4. You have a right to request a limitation or restriction on how I use or disclose your healthcare information for treatment, payment, or other health care operations. I am not required to agree with the request.
5. You have a right to request a written accounting of all occasions that I have disclosed or used your healthcare information for other than payment, treatment, or other operations. I will provide you with one copy of this accounting free of charge every 12 months. If you request this accounting more than once in a 12 month period, I will charge you a reasonable fee based on the cost of me tabulating these disclosures.
6. You have a right to request that I communicate with you about your healthcare information in a certain way or at a certain location.

Situations When Your Healthcare Information May be Shared

1. To consult with your other healthcare professionals like physicians or psychiatrists. I will only do this with written authorization from you.
2. To anyone you give written authorization to have your healthcare information. You have the right to revoke this authorization at any time. However, it will only effect your healthcare information from that point on.
3. To any person who is required by federal, state or local law to have lawful access to your healthcare information.
4. To a third party payer in order to receive payment for services I provide for you. This may include your insurance company that I may be an out of system provider for. All claims need to be filed by the client individually; if you need a receipt for services I provided for you, please ask.
5. For my business practices which include but are not limited to the following: my supervising staff, to improve the quality of my services, in connection with licensing, credentialing, or certification activities

or to evaluate the effectiveness of my services.

6. To a legal guardian, family member, person responsible for your care or a person designated as your personal representative in the event of an emergency. It is my responsibility to give you a chance to object to a disclosure of this kind. If you object, are not present, or are incapable of responding, I may use my professional judgment to disclose your healthcare information in your best interest during an emergency. It is still my responsibility to protect your healthcare information, so I will only use or disclose the parts of your healthcare information that are necessary or crucial at the time of the emergency.

*****When Your Healthcare Information can be Disclosed Without Your Authorization**

There are four circumstances in which I cannot guarantee confidentiality, legally and/or ethically:

1. When I believe that you plan and intend to harm yourself or another person.
2. When I believe that a child or elderly person has been or is in danger of being neglected or abused.
3. When ordered by a judge to release information about your healthcare information about your time with me.
4. Confidentiality is waived if I or any counselor is or becomes a party defendant to a criminal, civil or disciplinary action arising from a complaint filed by the client.

Your healthcare information which I retain for my records will be held for a minimum of seven years after your last session with me. When that 7 years has elapsed, your record will be destroyed in a way that protects your privacy such as shredding or burning.

None of your healthcare information will be used by me for marketing, development, or any other related activities without your written authorization. Without your written permission, I cannot use, share, or disclose your healthcare information in any ways other than those explained in this notice.

If at any point in time, you think your privacy and confidentiality rights have been violated by me, or you would like to file a complaint about my privacy practices, you may write to the North Carolina Board of Licensed Professional Counselors – PO Box 1369 Garner, NC 27529; Phone: 919-661-0820; Fax 919-779-5642.

Consent to This Privacy Policy

Please print, sign and date below, acknowledging this form and consenting to this form as a condition of receiving mental health services from Marcella P Graziano, MA, LPC.

I was given a copy of this notice and an opportunity to ask questions I had. I understand the terms of this notice and consent to them. I have the freedom to ask any questions I have at any time.

Client Signature _____ Date

Client's Printed Name _____ Date