*Glen D. Greenberg, PhD, ABPP*

## NOTICE OF PRIVACY PRACTICES
(HIPAA)

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) you have certain rights to privacy regarding your protected health information (PHI). This information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments.

If there is a breach of your confidentiality, then I must inform you as well as Health and Human Services. A breach means that information has been released without authorization or without legal authority unless I can show that there was a low risk that the PHI has been compromised because the unauthorized person did not view the PHI or it was de-identified.

If you are self-pay, then you may restrict the information sent to insurance companies.

Most uses of disclosures of psychotherapy notes and of protected health information require an authorization. Other uses and disclosures not described in the notice will be made only with your written authorization. You must sign a release of information form for releases that are not mentioned in this Privacy Notice (such as mandated reporting of child abuse, reporting of elder abuse, reporting of impaired drivers, etc.)

A more complete *Notice of Privacy Practices* containing a detailed description of the uses and disclosures of my health information is available upon request. The psychologist has the right to change the *Notice of Privacy Practices* from time to time and you may contact us at any time to obtain a current copy of the *Notice of Privacy Practices.*

You may request in writing that we restrict how your private information is used or disclosed to carry out treatment, payment, or healthcare services. You are not required to agree to our requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

Patient Name (Print): _____

Signature of patient or legal guardian: _____ Date _____

Relationship to Patient: ☐ Patient ☐ Parent ☐ Guardian ☐ Other _____