

## **Consent Form- Privacy Practices**

### **Notice of 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.

This Health Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for each of the following purposes: treatment, payment, and healthcare operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include sending your records for a consultation with a specialist. Payment means such activities as obtaining reimbursement for service, confirming coverage, billing or collection activities review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health Care Operations include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment issues, leaving a message if necessary. However, remembering your appointments is your responsibility. If you prefer to be contacted at an alternate address and/or telephone number, please notify our office in writing.

We may also communicate with you through email or text, we are making you aware that these communications will not be encrypted, HIPPA allows covered entities and their business associates to communicate e-PHI with patients via emails and texts if either (1) the emails and texts are encrypted and/or otherwise secure; or (2) the covered communication via unsecured emails or text, anyway. When it comes to communicating with non-patients, the covered entity or business associate must generally ensure that its email or texts comply with relevant Privacy and Security Rule standards.

You have the following rights with respect to your protected health information, which you can exercise by

presenting a written request to our Privacy officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified to you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example, receiving billing and/or telephone calls or emails at an alternate address. You must request this in writing.

The right to inspect and receive a copy of your protected health information, unless your provider deems this information harmful to your health. This may be subject to certain limitations and fees. Due to the nature of mental health treatment, any interest in inspecting your health record must be discussed with your provider first. Psychotherapy notes and raw test data resulting from psychological test administration are the property of the clinician.

The right to amend your protected health information. You must submit sufficient information to support your request for an amendment, This must be done in writing. Any amendment cannot alter the original record.

We are required by law to maintain the privacy of your protected health information and to provide you with the notice of our legal duties and privacy practices with the respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms and make new notice provisions effective for all protected health information that we maintain. We will post this information and you may request a written copy of a revised Notice of Privacy Practices from this office .

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office (see below for the address) or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

FORTIS BEHAVIORAL HEALTH  
220 Wintergreen Drive, Suite B  
Lumberton, N.C. 28358

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Office of Civil Rights

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200 Independence Avenue, S.W.  
Washington, D.C. 20201

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received or was offered and declined a copy of the Notice of Privacy Practices for the above named practice.

**PATIENT OR PARENT/GAURDIAN**

**SIGNATURE: \***

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**NAME OF SIGNER: \***

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**RELATIONSHIP TO PATIENT (IF SELF  
PUT SELF): \***

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**Date \***

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