Charlotte Therapy Associates
Diane Yee, MS, LPC
5200 Park Rd, Suite 219
Charlotte, NC 28209

Notice of Privacy Practices

HIPPA (Health Information Portability & Accountability Act) Law

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. PLEASE SIGN OR REFUSE TO SIGN THE FOLLOWING FORM.

My office is committed to and practices the following guidelines in order to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private; to give you this notice of my privacy practices, and to let you know if I make any changes in them. I consider *all information* about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form", stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for payment purposes. (As needed for billing, insurance claims and collections.) For treatment, health care operations and other cases, I will ask for your authorization for use and/or disclosure of you PHI. I may not disclose your PHI without your informed and voluntary written consent or authorization. (See also, Professional Disclosure.)

Disclosure of Information

Whenever your PHI is released or obtained, it will be the *minimum* information necessary. There are some situations in which release of information without authorization is required and/or permitted by law and professional ethics.

These include:

- Emergencies.
- Reporting of abuse or neglect.
- Disclosures required by court order.
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Your Rights Regarding Privacy

By law, you have certain rights regarding the health information that I collect and maintain about you. These rights include:

- The right to inspect and obtain a copy of your medical record.
- The right to request an amendment of any section of your medical record.
- The right to request *restriction* of disclosure of your PHI for the purposes of treatment, payment, and health care operations.
- The right to request an accounting of the disclosures that we make of your health care information.
- The right to request confidential communication.
- The right to a copy of this notice.
- The right to *refuse* to acknowledge receipt of this notice.

Questions and/or Exercising Your Rights

If you have any further questions and/or concerns about this notice please contact me. In order to exercise any of your rights described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to my office. You may also complain to the secretary of Health and Human Services, 200 Independence Avenue, SW, 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. I reserve the right to amend the terms of this notice.

THIS NOTICE IS EFFECTIVE OCTOBER 1, 2011

PLEASE KEEP THIS FOR YOUR RECORDS

Diane Yee, MS, LPC
5200 Park Rd, Suite 219
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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact Diane Yee, MS, LPC at dianeyee4@gmail.com or at 704-756-7802.

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative * Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, parent, etc.).

Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member & Date

_____

Please make a copy for your records.