ASSOCIATES IN NEUROPSYCHOLOGY AND BEHAVIORAL HEALTH

Neuroscience and Surgical Institute of Delaware • 774 Christiana Road • 201A • Newark, Delaware 19713
Mailing Address: P.O. Box 594 • Westtown, PA 19395-0594

NOTICE OF PRIVACY PRACTICES
(HIPAA)

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my 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 (the covered entity) 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 an authorization (release of information form) for releases that are nor 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 in the office. I have the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that the psychologist has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that my psychologist restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (Print): _____

Signature of patient or legal guardian: _____ Date _____

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