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**HIPAA Notice of Privacy Practices**

This notice describes how your medical information and other private information about you may be used and disclosed, and how you can get access to this information. **Please review it carefully and contact us with any questions**.

**At Peace Integrative Mental Health Clinic** is required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with this Notice of our legal duties and privacy practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The Health Insurance Portability and Accountability Act of 1996, includes important practices for healthcare organizations regarding the privacy and security of patient information.

Protected Health Information (PHI) is information about you and this information includes demographic information that may identify you. This identifiable individual information includes your name, date of birth, sex, social security number, medical history, and other personal information. This PHI relates to your past, present, or future physical or mental health or condition(s) and related health care services.

We are required to abide by the terms of this notice when we use or disclose your PHI. It is our responsibility and intention to protect your confidentiality to the fullest extent permitted by law. The notice details patient rights and our duties regarding their PHI. This notice describes how a patient’s PHI maybe use or disclosed to carry out treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. The PHI can be provided to us via our intake forms or other forms, by phone, fax, email, or other means.

**Your health information that is collected can be used for the following:**

**For treatment purposes**. We can use your health information and share it with other professionals who are treating you. These professionals include but are not limited to, primary care providers (PCP), therapists, case management, or other healthcare specialists.

**For Payment purposes**. HPI may be given to insurance companies and other third-party payers regarding services provided to the patient. Your information can be shared or used when determining your eligibility for our services and reimbursement for the services that were provided by the clinic to you.

**Other health care purposes:** We can also use and share your health information for practice improvement purposes (inspections, accreditations, and audits of our facility and services), or when required by law to do so.

Some examples in which information can be used or shared include.

* For public health purposes such as the Duty to Warn and Protect. If you disclose a plan or threat to harm others, the provider has a duty to attempt to warn the potential victim and notify the legal authority. For other public health purposes; the provider can notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
* Legal authorities may also be notified to prevent a serious threat to one’s health or safety. An example of this is if one has plans or a threat to harm themselves.
* If Abuse of Children and Vulnerable Adults is suspected or disclosed
* Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.
* To remind you of your appointment or services related to your care.
* When required by law (federal or state law) such as in the case of a court order or subpoena, lawsuits, disputes, law enforcement, workers’ compensation, and others.
* At your request, with a signed consent for Release of Information.

**Patient’s Rights**

* You have the right to access Protected Health Information (PHI). Upon your request, we will provide a copy of a summary of your health information. This may include an electronic or paper copy of your medical record and other health information that we have about you. Please be aware that access may be denied in some circumstances required by law such as PHI that is to be used in a civil, criminal, or administrative action or proceeding, etc. Please allow sufficient time to provide the requested information which is usually within 30 days of your request.
* You have the right to request restrictions on how we use and disclose your PHI. This can include sharing information with insurance or third-party companies. Please be aware that your request may be denied if required by law or if it will affect the care or the operations of the clinic and payments for patients that pay for services through their insurance companies.
* You have the right to request to amend or correct your PHI. An explanation will be provided to you in writing if we are unable to honor such a request.
* You have the right for your medical power of attorney or legal guardian to act on your behalf and make decisions regarding your health information.
* You have the right to be notified in the event of a breach of your PHI.
* You have the right to file a complaint without retaliation if you feel we have violated your rights by contacting us or by filing a complaint with the U.S. Department of Health and Human Service Office. A letter can be sent to 200 Independence Ave, S.W., Washington D.C. 20201, calling 1-877-696-6775, or by visiting [www.hhs.gov/ocr/privacy/hipaa/complaints /](http://www.hhs.gov/ocr/privacy/hipaa/complaints%20/).
* You have the right to refuse to give some or all your health information. Please know that we may limit the services/care that we can provide for you, or we may not be able to provide care/services for you.
* You have the right to ask and receive a copy of this privacy notice at any time.

Please note that we may make future changes to this notice if needed for practice improvement purposes or to comply with any changes related to privacy laws. Any new changes made will apply to PHI that was obtained/received or collected prior to the notice change. A hard copy or electronic version of the Notice will also be available upon the patient’s request.

Your authorization for us to use or disclose your health information may be revoked in writing by you or your guardian at any time. Please be aware that the revocation will not be effective for information that has already been used and disclosed*.*

Your signature below acknowledges that you have received and reviewed the Notice of Privacy Practices.

**HIPAA Compliance Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

May we phone, email, or send a text to you to confirm appointments? **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we discuss your medical condition with any member of your family? **YES NO**

If YES, please name the members allowed:

Patient’s Name **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Birthdate**\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Date: **\_\_\_\_\_\_\_\_\_\_\_\_**

Parent/Guardian: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_**

**\*By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your handwritten signature.**