



## HIPAA POLICY 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.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA 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.

**Treatment** means providing, coordinating, or managing healthcare and related services by one or more health care providers. An example of this would be a psychotherapy session.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization 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 aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review. We may create and distribute deidentified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

**You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the privacy officer:**

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested 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
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office 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.

Please contact the following for more information:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, DC 20201

201-619-0257



## Acknowledgement of HIPAA Privacy Notice

Cognitive Assessment & Referral Services PLLC is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

- I acknowledge that I have received a copy of CARES' HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.
- I have read the notice and was given the opportunity to have any questions answered regarding the notice.
- I understand CARES cannot disclose my health information other than as specified in the notice.

---

Patient Name

---

Patient Signature

---

Date