NOTICE OF PRIVACY OF PRACTICES
FACT SHEET

I am required by law to make sure that medical information that identifies you is kept private, give you this notice of my legal duties and privacy practices with respect to medical information about you, and follow the terms of the notice that is currently in effect.

I MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

For Treatment
For Payment
To Individuals Involved in Your Care or Payment for Your care
To Determine Treatment Alternatives
For Health-Related Benefits and Services
For Health Care Appointment Reminders
To Coroners or Medical Examiners
For National Security and Intelligence Activities
As Required By Law Enforcement
Military and Veterans
To Avert a Serious Threat the Health or Safety
To Workers Compensation
To Resolve or Prevent Public Health Risks
In You Are an Inmate
In Lawsuits and Disputes
For Health Oversight Activities

- You have the right to inspect and copy medical information that may be used to make decisions about your care.
- If you feel that medical information I have about you is incorrect or incomplete, you may ask that the information be amended. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, your request may be denied if the information requested to be amended: was not created by me, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by myself or Harmony Counseling Center; is not part of the information which you would be permitted to inspect or copy; or is accurate and complete.
- You have the right to request a list of the disclosures I have made of medical information about you other than our own uses for treatment, payment and health care operations, as those functions are described above.
- You have the right to request a restriction or limitation on the medical information I use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.
- I am not required to agree to your request. If I do agree**, I will information is needed to provide you emergency treatment.**
- You have the right to request that I communicate with you about medical matters in a certain way or at certain location.
- You have the right to a paper copy of this notice.

I reserve the right to change this notice. Each time services are initiated; I will offer you a copy of the current notice in effect. If you believe your privacy rights have been violated, you may file a complaint with the: Secretary of the Department of Health and Human Services. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission.

I have read this notice and have received a full copy of the “Notice of Privacy Practices” which more fully explains these practices, lists examples and provides phone numbers for contact.

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Client Signature Date