Breathe Mind Body Therapy, LLC
Joni Evans, LMFT, LCPC

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.

In the course of providing healthcare to you, we collect, make, use, store and disclose information about you and your healthcare. Federal and State law require that when health information about a person can be used to identify that person, the privacy of that health information must be protected. For this reason, such health information is known as "Protected Health Information", or "PHI" for short.

Breath Mind Body Therapy is required by law to give you this Notice to tell you how we will use and disclose your PHI, what our practices are to protect it, and what your rights are. This Notice is provided to you jointly by Breath Mind Body Therapy and its employees, staff and others, within and outside its operations, who we permit through an organized healthcare arrangement to be involved in your treatment, payment for services, and in our operations. All such persons and entities that join in this Notice may use and disclose information about you as described herein. We are allowed to change this Notice if we deem necessary, and we may change it in the future. We will follow the terms of the most current version of the Notice we have published. Any revised version of this Notice will be effective for all PHI we maintain at the time of the revision and which we receive or create thereafter. You may request a copy of the most current version of this Notice. An additional legal requirement we have is to obtain acknowledgment from you that you have received this Notice. For this reason you will be asked to sign a form acknowledging receipt of this Notice.

HOW WE USE AND DISCLOSE YOUR PHI

1. Use and Disclosure of Your PHI <u>Without</u> Your Authorization.

A. Circumstances when we might use and disclose your PHI, or the purposes for doing so, are set forth below, along with some examples. But you should understand that not all circumstances, can or will be listed and described, and not every example can or will be provided.

B. For Treatment. We may use your PHI within our organization and disclose it to others outside our organization for purposes related to your healthcare. For example, your PHI may be used to create and carry out a plan of treatment for you, or it may be disclosed to labs, or to others we may refer you to for evaluation or treatment.

C. For Payment. We may use or disclose your PHI to obtain payment for healthcare services you receive. For example, we may use and disclose PHI in billing your health plan for healthcare services provided to you, or to describe services for case management activities.

D. For Healthcare Operations. We may use and disclose PHI in order to manage our programs and activities. For example, we may use PHI to review the quality of services you receive from us, or disclose it to accreditation organizations for the purpose of obtaining and/or maintaining accreditation.

E. Appointments and Other Health Information. We may send you reminders of healthcare appointments. We may send you information about health services that may be of interest to you.

F. Disclosures to Family, Friends and Others. We may disclose PHI to your family, or close personal friends or other persons who are involved in your medical care and/or the payment for it. (You have the right to object to the sharing of information with these persons.)

G. For Disaster Relief Purposes. We may disclose PHI to government agencies for the purpose of notifying family members or close personal friends about an individual's medical condition. (You have a right to object to the sharing of information for this purpose.)

H. To Business Associates. We may disclose PHI to certain entities or individuals outside our organization that we engage to perform services on our behalf, provided they agree to appropriately safeguard the privacy of the PHI.

Other Uses and Disclosures. We are also permitted or may be required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority or for a government program (for example, for determinations of benefit eligibility);
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- To the military about its members or veterans; to government agencies for intelligence or national security purposes; to a correctional institution or a law enforcement official about an inmate or an individual in custody; and
- For compliance with workers' compensation programs.

2. Other Uses and Disclosures Require Your Written Authorization. Except for the circumstances mentioned above, we will ask you for your written authorization before using or disclosing information. If you provide us with such an authorization, you may cancel it at any time in writing. Obviously, if you cancel an authorization, we cannot take back any uses or disclosures, which we had already made with your authorization.

3. Your Rights Concerning Your PHI. The following is a summary of your rights with respect to your PHI:

- You have the right to inspect and copy your PHI, as permitted by law.
- You have the right to request restrictions regarding the uses and disclosures of your PHI. (We do not have to agree to your request, however.)
- You have the right to a request to receive confidential communications from us by alternative means or at
- an alternative location.
- You have the right to request that we amend your PHI. (Your request must state a reason for the requested amendment.)
- You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.
- You have the right to obtain a paper copy of our Notice of Privacy Practices from us.

COMPLAINTS

You may complain to us or to the Secretary of the Department of Health and Human Services if you believe the privacy of your PHI has not been properly protected or your privacy rights have been violated by us. Complaints filed with us must be filed in writing. There will be no retaliation for filing a complaint.

Breathe Mind Body Therapy

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOTE: We are required by law to provide each patient a copy of our Notice of Privacy Practices, obtain an acknowledgment that the Notice was provided, and keep the acknowledgment in our records. Along with the Notice of Privacy Practices, you will be given a copy of this acknowledgment for your records.

ACKNOWLEDGMENT OF PATIENT

I acknowledge that on the date indicated below I was provided a paper copy of the Notice of Privacy Practices of *Breathe Mind Body Therapy*. I understand that this Notice describes how medical information about me may be used and disclosed and how I can get access to this information. I understand that I should review the Notice of Privacy Practices carefully.

_____	_____	_____
Print Name	Signature	Date

ACKNOWLEDGMENT OF PERSONAL REPRESENTATIVE

I acknowledge that on the date indicated below, I represented that I am the personal representative of the patient named below and that I was provided a paper copy of the Notice of Privacy Practices of *Breathe Mind Body Therapy* on behalf of this patient. I understand that this Notice describes how medical information about the patient may be used and disclosed and how I can get access to this information. I understand that I should review the Notice of Privacy Practices carefully.

_____	_____	_____
Name of Personal Representative (Print)	Signature of Personal Representative	Date

_____	☐Parent ☐Other:_____
Name of Patient (Print)	Basis of Personal Representative Status