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SPEECH-LANGUAGE PATHOLOGIST*

## **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.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of Your Health Care Information**

#### **Treatment**

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. (example)

*On occasion, it may be necessary to seek consultation regarding your condition from other speech therapy providers associated with this practice. ||*

*It is our policy to provide a substitute speech therapy provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary speech pathologist's absence due to vacation, sickness, or other emergency situation.*

#### **Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this practice for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received. ||*

#### **Workers' Compensation**

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

#### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition- or in the event of an emergency or of your death.

#### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

#### **Judicial and Administrative Proceedings.**

We may disclose your health information in the course of any administrative or judicial proceeding.

#### **Law Enforcement.**

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

#### **Research.**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

### **Public Safety.**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

### **Specialized Government Agencies.**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

### **Change of Ownership.**

In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

### **Changes to this Notice of Privacy Practices**

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Privacy Officer by calling this office.

**Complaints**

Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200  
Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

**This notice is effective as of** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**I have read the Privacy Notice and Understand my rights contained in the notice.**

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

\_\_\_\_\_  
Patient's Name (PRINT)

\_\_\_\_\_  
PATIENT REPRESENTATIVE SIGNATURE (parent)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Authorized Facility Signature:

\_\_\_\_\_  
DATE