**NOTICE OF PATIENT PRIVACY PRACTICES**

I am committed to preserving the privacy of your personal health information. In fact, I am required by law to protect the privacy of your clinical information and to provide you with Notice. Recent federal legislation requires that I issue this official notice of my privacy practices. Please review it carefully.

**HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION**

* I am required by law to have your written consent before I use or disclose to others your clinical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that I provide to you, and the related administrative activities supporting your treatment.
* I may be required or permitted by certain laws to use and disclose your clinical information for other purposes without your consent or authorization.
* As my patient, you have important rights relating to inspecting and copying your clinical information that I maintain, amending or correcting that information, obtaining an accounting of our disclosures of your clinical information, requesting that I communicate with you confidentially, requesting that I restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.
* I have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. I may revise our NOTICE from time to time. The Effective Date at the bottom left hand side of this page indicates the date of the most current NOTICE in effect.
* You have the right to receive a copy of my most current NOTICE in effect. If you have not yet received a copy of my current NOTICE, please ask me and I will provide you with a copy.
* If you have any questions, concerns or complaints about the NOTICE or your clinical information, please talk to me during our session or if it is urgent or call me at (929) 515-4102.

Patient Name: Date of Birth:

I received this practice’s Notice of Privacy Practices. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice’s legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice or Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice’s current Notice of Privacy Practices on request.

Signature: Date: