Lital Diament MA LMFT Lic: 96310

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 & Accountability Act of 1996 ("HIPAA") is a federal law that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronic, on paper, or orally, are kept properly confidential. HIPAA gives you, the client, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. Each time you meet with your psychotherapist, a record is made to ensure the best possible care. This notice applies to all of the records of your care generated by Lital Diament MA LMFT

How I May Use and Disclose Medical Information About You:

Treatment: I may use and disclose medical information about you to provide, coordinate, and manage your treatment or services. I may disclose medical information about you to doctors, other therapists, or others who are involved in your treatment only with your written authorization. For example, if a referral is made to another health care provider. I may provide oral information and copies of various reports that should assist her or him in treating you.

Payment: I may use and disclose medical information about you in order to obtain reimbursement for services, for billing or collection activities.

Health Care Operations: I may use and disclose, as needed, your health information in order to support my business activities, licensing, legal advice, and customer service. For example, I may call you by name in the waiting area. Additionally, there are other business professionals using the offices and you may encounter them upon arrival and departure from our sessions.

Other Uses and Disclosures: I may use and disclose your health information in an emergency situation to prevent harm to yourself or others. An example would be mandated reporting of abuse to children, the elderly, a disabled person, or when a judge orders the release of information. I may create and distribute de-identified health information by removing all references to individually identifiable details. I may contact you to provide appointment reminders, or to offer information about treatment alternatives or other health-related benefits and services that may be of interest to you. 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.

Your Rights:

You have the right to participate in developing an individual plan for treatment
You have the right to receive an explanation of services in accordance with the treatment plan
You have the right to participate voluntarily in and to consent to treatment
You have the right to object to, or terminate, treatment
You have the right to access your records
You have the right to receive clinically appropriate care and treatment that is suited to your needs that is administered safely and with full respect for your personal integrity
You have the right to be treated in a manner that is ethical and free from abuse, discrimination, mistreatment and/or exploitation
You have the right to be informed of expected results of all therapies prescribed including possible adverse effects
You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint to me or with the federal government. I will not retaliate against you for filing a complaint. Department of Health & Human Services, Office of Civil Rights 200 Independence Ave. S.W. Washington, D.C. 20201. 1-877-696-6775 or (202) 619-0257.
By signing below, I, (printed name) _____, acknowledge that I have read and agree to the above written information.

_____ Date: _____
Client Signature Date

_____Date:_____
Lital Diament MA LMFT