BONITA E. FISHER, PSY.D.
206 WEST BROAD ST.•BETHLEHEM,PA.18018
484.895.4988

Notice of Privacy Practices – Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A Commitment to Your Privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I am required to give you this information. This is a short version of the full, legally required Notice of Privacy Practices. The longer form is available upon request. This notice is effective 04/01/10 and applies to all protected health information as defined by federal regulations.

I will use the information about your health which I obtain from you or from others mainly to provide you with **treatment** (including clinical review with supervising psychologist), arrange **payment** for my services (including receipts to you for insurance reimbursement, if applicable), and for some other business activities which are called, in the law, health care **operations** (for example, the giving and scoring of certain tests). After you have read this Notice I will ask you to sign a **Consent Form**, to allow me to use and to share (see below) your information. If you do not consent and sign this form, I cannot treat you.

If you or I want to use or disclose (send, share, release) your information for any other purposes I will discuss this with you and ask you to sign an Authorization Form to allow such disclosure.

Of course I will keep your health information private, but there are some circumstances in which disclosure is required by law, such as:

- Any known or reasonable suspicion of any abuse or neglect of a minor or an elder, danger of suicide, a licensed driver unable to drive safely. I will only share information with a person or organization that is able to help prevent or reduce the threat.

- With a signed court order, in legal or court proceedings.

- If a law enforcement official requires me to do so.

• For workers' Compensation, No Fault insurance, or other similar programs established by law (to the extent authorized by and necessary to comply with said laws).

The longer version is available to you for additional clarification on these laws.

Your Health Information Rights

• Obtain a copy of this notice of information. Should the information practices change, there will be a revised notice posted in the waiting area of the office.

• Request communications of your health information by alternative means or locations (e.g., you can request that I contact you at home and not at work, or vice versa).

• Request a restriction on certain uses and disclosure or your information as provided by 45 CFR 164.522.

• Revoke authorization to use or disclose health information, except to the extent that action has already been taken with your prior authorization.

• Inspect and obtain a copy your health record as provided for in 45 CFR 164.524.

• Amend your health record as provided in 45 CFR 164.528 (with written request and specific reason).

• Obtain an accounting of disclosures of your health information, as provided in 45 CFR 164.528.

• To file a complaint if you believe that your privacy rights have been violated. You can file a complaint with me and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

• I have the right to charge for work and copying for the above.

If you have any questions regarding this notice or the health information privacy policies, please ask me. The effective date of this notice is April 1, 2010.

Also, you may have other rights which are granted under state law, which may be either different or in accordance with the rights described above.

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I have read the brief version of the Notice of Privacy Practices and consent to the policy contained therein.

_____ _____ _____
Printed Name Signature Date

I understand that a longer version of the Notice of Privacy Practices is available and that I may request access to it at any time. (initials) _____

Messages which are left to return a phone call or to change or confirm an appointment may be left _____ on the answering device or _____ with any person at this number:

_____

Do NOT leave messages at this/these number/s: _____ _____