Southlake Autism and Behavior Services, PA

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Notice of Protected Health Information Privacy Practices
Generalized Consent for Treatment

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

When this document refers to "you" or "your" below, it represents your child or the patient receiving services from Southlake Autism and Behavior Services, PA. The initials SABS are used to represent Southlake Autism and Behavior Services, PA.

As part of the healthcare service you receive from Southlake Autism and Behavior Services, PA, health records are generated and maintained describing your child's care including, but not limited to, your name, address, phone number, social security number, health history, symptoms, examination and test results, diagnoses, procedures, treatments, and plans for future care or treatment. This information is called "Protected Health Information" (PHI). This Notice of Privacy Practices describes how Southlake Autism and Behavior Services, PA may use and disclose your information and the rights that you have regarding your health information.

Uses and Disclosures of Health Information without Authorization

When you obtain services from Southlake Autism and Behavior Services, PA, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment, and to support the operations of the entity and other involved providers. The following categories describe ways that we use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

- Your health information will be used for treatment: For example: Disclosure of medical information about you may be made to therapists, doctors, nurses, technicians, or others who are involved in treating you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Information may be shared with pharmacies, laboratories, or radiology centers for the coordination of different treatments.
- Your health information will be used for payment: For example: Health information about you may be disclosed so that services provided to you may be billed to an insurance company or a third party for reimbursement of services rendered. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.
- Your health information will be used for health care operations: For example: This information in your health record may be used to evaluate and improve the quality of the care and services we provide.

Disclosures Required by Law or Otherwise Allowed Without Authorization or Notification

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

- When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or for law enforcement; examples would be reporting gunshot wound or child abuse, or responding to court orders
- For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to food, medications, or devices
- For health oversight activities, such as audits, inspections, or licensure investigations
- To organ procurement organizations for the purpose of tissue donation and transplant
- To avoid a serious threat to the health or safety of a person or the public
- Contacting you to provide appointment reminders or to recommend treatment alternatives
- Notifying you of health-related benefits and services that may be of interest to you

Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

Uses and Disclosures Requiring Authorization

Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

YOUR INDIVIDUAL RIGHTS UNDER HIPAA

- You have the right to request restrictions on certain uses and disclosures of your Protected Health Information. For example, you may wish to restrict your employer from knowing about a medical condition. Regardless of your request, please know that the HIPAA rules allow our office to share your Protected Health Information with the Covered Entities. If you wish to restrict your PHI please make this request in writing to SABS and discuss with your therapist.
- You have the right to receive your Protected Health Information in a confidential communication from our office, such as the US mail. If you have a specific request for communication please discuss this with your therapist or Terri Howard, SABS owner.
- You have the right to inspect and copy your Protected Health Information. Copies of your Protected Health Information are available for a reasonable fee paid to our office to cover our expenses of reproducing them. You may request this information at any time via your therapist, the office manager, or Terri Howard, SABS owner.
- You have the right to request that we amend your Protected Health Information. In some cases, we may require that these requests be in writing and be supported by a reason for the change. Generally, this will not apply to such routine changes as address or phone number listings.
- You have the right to receive, upon request, an accounting of your Protected Health Information that we have provided to Non-Covered entities.
- If you have read and responded to this notice through electronic media such as our website or email, you have the right to receive a paper copy of this notice upon request.

If you would like to exercises any of these rights, please contact Terri Howard (SABS owner) at (352) 223.1999 and we will make any necessary arrangements for you.

Southlake Autism and Behavior Services, PA is required by law to maintain the privacy of your Protected Health Information and to provide you with this notice of our legal duties and privacy practices as they apply to your Protected Health Information. We are also required to abide by the terms of this notice, which is currently in effect as of December 15, 2012.

In the future, we reserve the right to change the terms contained in this notice and make any new provisions effective for all of the Protected Health Information we maintain. In the event we elect to change the terms of this notice, a new notice will be posted in our office. In addition, you may receive notification by direct mail, email, or other such communication as our practice may implement from time to time.

Should you ever believe your privacy rights have been violated, we request you to file a complaint with our office by contacting us at (352) 223.1999 or by mail to: 409 East Oakland Avenue, Suite B, Oakland, FL 34787. You may also register your complaint with the Secretary of the US Department of Health and Human Services, Office of Civil Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy. Any complaint you file will be used strictly to improve our operating procedures and in no way will you be retaliated against for filing a complaint.

Should you have any questions or concerns, please contact SABS owner Terri Howard directly at (352) 223.1999 to obtain further information.

Generalized Consent for Treatment

I have read and understand the Notice of Protected Health Information Privacy Practices for Southlake Autism and Behavior Services, PA. I understand that if I do not sign this consent form my child cannot be evaluated or treated by Southlake Autism and Behavior Services, PA.

When Southlake Autism and Behavior Services, PA examines, treats, or refers your child, we will be collecting what the law calls Protected Health Information (PHI) about your child. We need to use this information to decide on what treatment is best for your child, provide treatment to your child, and collect payment. We may also share this information with others who provide treatment to your child or need it to arrange payment for your child's treatment or for other business or government functions.

By signing this form you are agreeing to let me use your child's Protected Health Information (PHI) for the purposes of payment, treatment, and health care operations.

Consent to Communicate Through Email, Phone and to Leave Voice Messages

You have a choice and a right to tell us how you want us to communicate your treatment and health information with you, if you are unable to agree to the following: I agree to accept and allow any representative from Southlake Autism and Behavior Services (SABS) to send information regarding treatment to me through email addresse(s) provided to SABS on the initial intake forms and any email address I provide SABS with in the future. I understand that information sent is unencrypted and carries a risk of interception. I agree to hold SABS harmless in the event that my personal, financial or protected health information is accidently, inadvertently or maliciously obtained by outside parties. I agree to allow voice messages to be left on all numbers provided to SABS that contain private and protected health information related to the treatment. I agree to allow SABS representatives to text or respond to my text messages as a means of communication related to therapy sessions, times, locations and the like. I further agree to notify SABS in writing if I desire to make any changes to this consent. I understand that verbal requests of changes cannot be guaranteed to be implemented. I understand I must submit this request in writing and ensure its receipt by the current acting Director of Clinical Services. I understand that only written requests can be honored for changes in communication preferences. Further, I understand that change in my communication preference may not be implemented immediately until all relevant individuals related to my case are notified and then, they are given a reasonable amount of time to make the necessary changes to ensure compliance.

Patient's printed name: _____

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____

Date Signed: _____

Witness: _____