



Miami Beach, Florida
Tel: (646) 242-4610 • Email: tracyspitz@gmail.com

HIPAA NOTICE OF PRIVACY PRACTICES TS Therapy Inc.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. I reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Those changes may apply to any of your protected health information that I maintain.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by TS Therapy Inc. that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of TS Therapy Inc. and any other use required by law.

Treatment: I will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations I may use or disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. I may also use or disclose health information for legal services, billing services, insurance eligibility, and claim payments.

I may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Required Uses and Disclosures. Under the law, I must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your provider has taken action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS: The following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. You must



Miami Beach, Florida
Tel: (646) 242-4610 • Email: tracyspitz@gmail.com

submit your request in writing to your provider. If you request a copy of the information, I will fill this request at no charge once every 12 months. I may charge a fee for the costs of copying, mailing or other supplies and services associated with your request, for additional requests made within the 12 month period. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. In the case of a child custody issue, I will need a legal documentation stating that no information is to be released to the person to whom you want the restriction to apply. Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to revoke. You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that this revocation of Consent will not affect any action I took in reliance on this Consent before I received your revocation and that I may decline to treat you or to continue treating you if you revoke this Consent. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively ie. electronically. You may have the right to have your provider amend your protected health information. If I deny your request for amendment, you have the right to file a statement of disagreement with us and I may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures I have made, if any, of your protected health information. You have the right to receive a list of instances in which I or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, I may charge you a reasonable, cost based fee for responding to these additional requests.

Complaints: If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about access to your health information or to have us communicate with you by an alternative means or alternative locations, you may complain to us using the contact information provided herein. You also may submit a written complaint to the U. S. Department of Health and Human Services. I will provide you with the address to file your complaint with us or the S. S. Department of Health and Human Services. I will not retaliate against you for filing a complaint.

This notice was published and becomes effective October 24, 2010.

Licensed professionals are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. Signature below is only acknowledgement that you have received this "Notice of our Privacy Practices" and understand that this notice will be filed with your child's health information record.

Patient's Name: _____ Date of Birth: _____
Parent or Legal Guardian (Print Name): _____ (Signature): _____
Relationship to Patient: _____ Date: _____