Deborah Levi Lane, LCSW, PLLC

SUMMARY NOTICE OF HIPAA PRIVACY PRACTICES

Privacy Practices: I am required by law to follow the practices described below. This is a summary of my Privacy Practices but does not replace the full version which will be made available to you upon request. This notice applies to personal health information that I have about you, and which are kept in my office and/or computer. With some exceptions, I must obtain your authorization to disclose (or release) your health care information. There are some situations in which I do not have to obtain your authorization.

Health Information about you can be used to:

- Plan your treatment and services.
- Submit bills to your insurance, Medicare or third-party payors.
- Obtain approval in advance from your insurance company
- Exchange information with Social Security, Employment Security or Social Services
- Measure my quality of services

I may use your personal information without your permission:

- To make appointment reminders
- To treat you in an emergency
- To exchange information with other State agencies as required by law
- To inform you about possible treatment options
- For agencies involved in a disaster situation
- For certain types of research
- When there is a serious public health or safety threat to you or others
- When ordered to do so by a court
- To communicate with coroners, medical examiners and funeral homes when necessary for them to do their jobs
- To communicate with federal officials involved in security activities authorized by law
- To communicate with law enforcement if you are a victim of a crime, involved in a crime at my office, or you have threatened to commit a crime.
- As required by State, Federal or local law.

You have the right:

- To see and get a copy of your clinical record (with some exceptions)
- To appeal if I decide not to let you see all or some parts of your record
- To ask for the record to be changed if you believe you see a mistake or something that in not complete. I may deny your request if I believe the record is accurate and complete.
- To know to whom I have sent information about you.
- To limit how I use or disclose information about you. Requests must be made in writing.
- To have a paper copy of the Notice of Privacy Practices

Please sign below that you have read and understand my privacy practices:

_____ _____

Patient or Guardian Signature Date