HIPAA Privacy Notice

This HIPAA (Health Insurance Portability and Accountability Act) Notice describes how speech-language therapy information and other relevant medical information about you/your child may be used and disclosed and how you can get access to this information. Please review it carefully.

Commitment to privacy

We are dedicated to protecting your privacy and health information. In serving our patients, and to comply with applicable laws, we create records regarding evaluation and treatment. We are required to keep this information safe and secure. We will only share your information in accordance with state or federal law and in keeping with ethical standards of practice.

Types of personal health information we may collect and store:

- Notes from doctors, teachers, or other healthcare providers
- Evaluation results
- Treatment plan, notes, and results
- Medical history
- Insurance information

How we might use and share this information:

- To provide treatment
- To share with other medical professionals involved in your care
- To run our practice, including billing for services
- To do research or help with public health and safety issues
- To comply with the law, including disclosures if abuse or neglect is suspected

You have the right to:

- Receive a copy of your paper or electronic treatment records
- Request corrections to information collected about you
- Request confidential communication
- Ask us to limit the information we share (especially with regard to how information is shared with your friends and family or when marketing our services)
- File a complaint if you feel your information has been shared in a way that violates HIPAA policies

Requests must be made in writing and not all requests can or will be fulfilled.

We must inform you before we share your medical information in a way that is not mentioned in this notice.

This HIPAA policy is subject to change and we will provide you a copy of the updated notice.

If you have any questions, please ask your speech-language pathologist.

I HAVE READ AND UNDERSTOOD THE PRIVACY POLICIES DISCLOSED IN THIS NOTICE

Your Signature: _____ Date: _____

Patient Name: _____ Relationship to Patient: _____

Speech Pathologist Name and Credentials
Practice Name
Practice Street Address
Practice City, State, Zip
Practice Phone/Fax