Stephan P. Michener, LCSW, SAP
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Fairport, NY 14450
(585) 383-4478

Notice of Privacy Practices

This notice of Privacy Practices describes how your Protected Health Information (PHI) may be used and disclosed in accordance with applicable federal and state laws. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment Your PHI may be used and disclosed by those involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. I may disclose PHI to any other provider only with your authorization.

For Payment I may use and disclose PHI so that I can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for the purposes of collection.

For health care operations I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI.

Required by Law Under the law, I must make disclosures of your PHI to you upon your request.

Without Authorization Applicable laws and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations.
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights please contact me.

- Right of access to inspect and copy. You have the right, which may be restricted, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy will be restricted in those situations where there is compelling evidence that access would cause harm to you. I may charge a cost based fee for time to review and copies.
- Right to amend. If you feel that PHI I have about you is incorrect or incomplete, you may ask me to amend that information, although I am not required to agree to the amendment.
- Right to an accounting of disclosures. You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge a fee for this accounting.
- Right to request restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- Right to request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way (e.g. phone, mail, email, etc) or at a certain location (e.g. home, office, etc).
- Right to a copy of the Notice. You have a right to a copy of this notice.

The effective date of this Notice is January 2018

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name ____

DOB: ___________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Stephan Michener's Notice of Privacy Practices.

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Signature of Patient/Client Date

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Signature of Parent, Guardian or Personal Representative* Date
*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt____________

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Stephan P. Michener, LCSWR Date