

NOTICE OF PRIVACY PRACTICES

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

- 1. Uses and Disclosures:** *Helping Hands Care Agency, LLC* is permitted by law to disclose the minimum necessary personal health information of each client to carry out treatment, payment, and health care operations of this Agency. For treatment purposes, such disclosures may be made to physicians and other health care providers as necessary to effectuate the appropriate treatment and care of clients. Personal health information may be disclosed to the government or other third party payors for the purpose of obtaining payment for services provided. This Agency may also use personal health information to carry out day-to-day operations such as scheduling, quality review and appointment reminders. A list of other examples of disclosures can be obtained from the Administrator upon request.
- 2. Required Authorizations:** This Agency will not disclose any client's personal health information for any purpose aside from payment, treatment and health care operations, without the client's authorized consent to such disclosure. Upon request for such authorization, the client shall have the right to refuse and/or revoke any disclosure of the client's personal health information.
- 3. Privacy Compliance:** In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 (the "Privacy Regulations"), Agency has adopted privacy policies regarding usage of client's personal health information. This Agency is committed to compliance with the Privacy Regulations and all other laws and regulations regarding clients' right to privacy.
- 4. Additional Information:** For additional information regarding the Agency's privacy policy notice, please contact the Administrator. This Agency reserves the right to change this Notice and to make the revised and changed Notice effective for medical information that the Agency already has about you, as well as any information the Agency receives in the future. We will post a copy of the current Notice in our offices. The Notice will contain the effective date. The client will receive a copy of this Notice upon admission.

The following signature acknowledges that the client has received notification of their privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

Client Name (Print) _____ Date _____

Client Name (Signature) _____

Agency Representative (Signature) _____ Date _____