



Child's name: (please print): _____

Child's date of birth: _____

HIPAA 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.

This Notice of Privacy Practices describes how we, *Lighting the Way Pediatric Occupational Therapy Services, LLC* may use and disclose your protected health information to carry out treatment, payment or health care options 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.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosing protected health care information to a patient's physician, teacher and other health care providers (when necessary) and also understand that the information used or disclosed may be subject to re-disclosure by the individual or facility receiving the information.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services.



Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your therapist's practice. This may include the training of occupational therapy students. We may call you by name in the waiting room when your therapist is ready to see you. Your protected health information may be used or disclosed when providing you with appointment reminders by contacting you via telephone, voicemail, e-mail or text.

We 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: Corners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we 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 unless required by law.

Your Rights

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. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that 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 the Notice of Privacy Practices.



I, _____ am the legal parent/guardian of
_____ and have legal authority to make any health care decisions
regarding this child.

As the parent/legal guardian of the above child, I authorize the following individuals to
accompany my child to therapy and have access/knowledge of the protected health
information.

Name:	Relationship:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Complaints

If you believe your privacy rights have been violated, you may file a complaint to our
practice, *Lighting the Way Pediatric Occupational Therapy Services, LLC* or to the
Secretary of Health and Human Services. All complaints must be submitted in writing.
You will not be penalized for filing a complaint.

You may revoke this authorization by notifying **Jennifer DeMastrie, OTR/L**
and/or **Lighting the Way Pediatric Occupational Therapy Services, LLC** in writing of
your desire to revoke.

This authorization expires when a patient is discharged by Lighting the Way Pediatric
Occupational Therapy Services, LLC or receives a written desire to revoke it.

Parent/Legal Guardian Signature

Date