

Notice of Privacy Practices

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Megan Romano, M.S., LMFT
Therapy for Individuals, Couples, Children & Families
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www.meganromano.com

Effective date: _____

Notice Of Privacy Practices, Policies and Procedures

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a client of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

My commitment to your privacy:

My practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, I will create records regarding you and the treatment and services I provide to you. I am required by law to maintain the confidentiality of health information that identifies you. I also am required by law to provide you with this notice of our legal duties and the privacy practices that I maintain in our practice concerning your PHI. By federal and state law, I must follow the terms of the Notice of Privacy Practices that I have in effect at the time.

I realize that these laws are complicated, but we must provide you with the following important information:

- How I may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by my practice. I reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for
5 all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

If you have questions about this Notice, please contact:

Megan Romano, M.S., LMFT by calling (631)-839-5887 or emailing
10 mromano@meganromano.com.

Use of your PHI:

I may use your health information for treatment purposes, to get paid for treatment
15 services, for administrative purposes, to evaluate the quality of care that you receive, to collaborate with other health care professionals in your treatment, appointment reminders and when required by law. In most cases, I will ask you for your written consent before using or disclosing your health information. If you sign an
20 authorization to disclose information, you can later revoke it to suspend further contact or disclosures.

Your rights regarding your PHI:

In most cases you have the right to look at or obtain a copy of your health
25 information. If you request copies, you may be charged a reasonable fee. If you believe that your health information is incorrect or information is missing, you have the right to request that I correct the existing information or add any information that is missing.

Professional Records:

New York State Law requires records to be kept of all client treatment for 6 years, or
30 until the client turns 22, whichever is longer. I keep a record of dates of service, fees as well as maintain progress notes to assist you with your treatment. I make a
35 practice of not keeping too much data in progress notes and observe security precautions in order to protect confidentiality.

Right to file a complaint:

If you believe your privacy rights have been violated, you may file a complaint with
40 our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with my practice, contact **Megan Romano, M.S., LMFT by calling (631)-839-5887 or emailing mromano@meganromano.com**. You will not be
45 penalized for filing a complaint.

Right to provide an authorization for other uses and disclosures:

5 This practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: I am required to retain records of your care.

10 Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Megan Romano, M.S., LMFT by calling (631)-839-5887 or emailing mromano@meganromano.com**

15 By signing this document, you acknowledge that you have had an opportunity to read and ask any questions regarding its contents. You acknowledge that you have received a copy for your records and that you understand fully what it communicates.

CLIENT SIGNATURE: _____

20 PRINTED NAME: _____

PROVIDER SIGNATURE: _____

PRINTED NAME: _____

25 DATE: _____