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NOTICE OF PRIVACY PRACTICES (Required by law)

The Health Insurance Portability and Accountability Act of 1996 is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us be kept properly confidential. As required by "HIPAA", following is an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- **Treatment** – providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** – such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- **Health care operations** – include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions and customer service.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to a staff member of the Little Bird Therapies.

- The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to request a copy of our current *Notice of Privacy Practices* at any time.

If you feel that your rights to privacy have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

I have read and understand the above *Notice of Privacy Practices* and understand that any information regarding my health care may be used for the purposes listed above. I also understand my rights as outlined above. (print to sign)

Signature of Patient / Guardian: _____ Date: _____

For the treatment of minors: I hereby grant permission for Therapy to be performed on this minor.

Parent Signature: _____ Date: _____

Signature: _____ Date _____