

Dayna Burnett, Ph.D
HIPPA Notice of Privacy
January, 2007

Patient Name _____ Date of Birth _____

THIS NOTICE DESCRIBES HOW YOUR PRIVATE HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Private Health Information may be used and disclosed in the following circumstances:

1. When required for public health issues such as workman's compensation.
2. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
3. When required by any state or federal law, including abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservist, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits.

You as the patient have rights to your private Health Information, including,

1. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored within 30-60 days.
2. The right to request information of any party that has requested information pertaining to your private health information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing, however, this will not affect any information already disclosed.

I, as a private practitioner have the responsibility to:

1. Make each patient aware of the Privacy Notice.
2. At any time make the necessary changes to Privacy Notice that are required by law.

If you as the patient feel your privacy has been violated you have the right to complain by filing a written complaint with the Secretary of Health and Human Services in Washington, D.C.

I _____, hereby authorize Dayna Burnett, Ph.D. to release private health information on my behalf to the following person(s):

Patient/Legal Guardian/Signature

Date

Witness

Date