

NOTICE OF PRIVACY PRACTICES

you in writing. If you pay for a health service “out of pocket” you may request that we not notify your health insurer regarding the service provided and we are required to honor your request.

You have the right to receive communications from us in a confidential manner.

Generally, you may request, in writing, to inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records. If we deny your request you may request that we review the reasons for the denial. Additionally, if your medical information is contained in our electronic health record you have the right to receive a copy of your record in electronic format subject to our form and formatting capabilities.

You may ask us to amend medical information about you in a medical record that we created. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

You have the right to receive an accounting of the disclosures of your medical information as required by law

You have the right to be notified of any breach of your unsecured health information.

If you received this Notice electronically, you may request a paper copy of this Notice of Privacy Practices for Protected Health Information

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way.

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

Contact Therapist:

Diana Gonzalez Joya, LCSW
7241 SW 63rd Ave, Ste.102A
Miami, FL 33143
(786) 229-6074

**THIS NOTICE IS EFFECTIVE AS OF MARCH 10, 2015
REVISION OF NOTICE OF PRIVACY PRACTICES**

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice on our website. We will make paper copies of the revised Notice of Privacy Practices available upon request.

Patient Signature (or legal representative)

Date

Printed name & Medical Record #

Witness (If patient refuses to sign)

Patient refused to sign

Patient Received Document