# NOTICE OF PRIVACY PRACTICES FOR MOLLI WILSON, PHD

## THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, I am required to provide you with my Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by me. It also tells you how you can obtain access to this information.

**Your Rights**

You have the right to:

- Terminate therapy at any time;
- Be informed about your treatment. Inspect and copy your information;
- Review your treatment plan and chart notes;
- Request corrections to your information;
- Request an amendment to the PHI maintained as part of the client's PHI
- Write a statement of disagreement if a requested amendment is denied
- Request confidential communication;
- Request that your information be restricted;
- A report of disclosures of your information;
- Get a copy of this privacy notice;
- File a complaint if you believe your privacy rights have been violated;

**Uses and Disclosures**

I may use and share your information as I:

- **Treat you.** Example, I will use health information about you to manage your treatment and services
- **Bill for your services.** Example: I will give information about you to your health insurance plan so it will pay for your services.
- **Help with public health and safety issues.** Example, as mandated by law, I must report suspected child or elder abuse, neglect, suicidal ideation or homicidal ideation. In the case of prenatal exposure to a harmful substance, I am required by law to contact legal authorities.
- **Comply with the law.** Example, I will share information about you if state or federal law requires that I do so.
- **Respond to lawsuits and legal action.** Example: I may be required by law to share health information about you in response to a court or administrative order, or in response to a subpoena.

**My Responsibilities**

- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me that I can in writing. If you tell me I can, you may change your mind at any time. Let me know in writing if you change your mind.
- I must agree to restrict disclosures to health plans if the PHI pertains to a health care item or service for which we have been paid in full.
- I am not required to agree to other requested restrictions.

**Changes to the Terms of this Notice**

We can change the terms of this notice and the changes will apply to all information that I have about you. The new notice will be available upon request, in my office and on my website.

**Filing a Complaint**

Please contact me **immediately** if you think that I have violated your rights in any way.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. I will not retaliate against you for filing a complaint.

**Acknowledgement of Notice of Privacy Practices**

"I hereby acknowledge that I have received a copy of **Molli Wilson, PhD, NOTICE OF PRIVACY PRACTICES.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that **Molli Wilson, PhD** will offer me updates to the **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.

Patient or Guardian's
Name:_____
(please print)

Patient or Guardian's
Signature:_____

Date:_____