AUTISM & ANXIETY
THERAPISTS

1100 Lake Street Suite 210E Oak Park, IL 60301
Email:dlabrose@aatherapists.com
FAX:847.264.4936

NOTICE OF PRIVACY PRACTICES

We respect our clients' confidentiality and only release information about you in accordance with state and federal laws.

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

This notice describes our policies related to the use of the records of your care at Autism & Anxiety Therapists Inc. We are required to give you this Notice about (1) the use and disclosure of your health information, (2) our legal responsibilities, and (3) your rights concerning your health information and to abide by the terms of this notice. You may request a copy of our Notice at any time.

1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We use and disclose the minimum necessary health information about you for your treatment, for payment for your services, and for Autism & Anxiety Therapists Inc., health care operations.

a. For Treatment. We use and disclose your health information internally in the course of your treatment at Autism & Anxiety Therapists, Inc. For example, we may give information to another Autism & Anxiety Therapists Inc. health care professional for the purpose of referral within the practice. If we wish to provide information outside of Autism & Anxiety Therapists Inc. for your treatment by another health care provider, we will have you sign an authorization to do so.

b. For Payment. We may use and disclose your health information to obtain payment for services we provide to you as delineated in the "Contract, Office Procedure, and Financial Agreement". We may need to give insurance companies or other agencies the minimum necessary information in order for them to pay us for the service we have provided to you.

c. For Health Care Operations. We may use and disclose your health information within Autism & Anxiety Therapists,Inc. as part of our internal health care operations. For example, this could mean a review of records to assure quality. Or, we may provide information to the student who is your therapist and is authorized to receive training at Autism & Therapists Inc. and to staff who supervise him or her. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

2. INFORMATION DISCLOSED WITHOUT YOUR CONSENT

Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances.

a. Emergencies. Sufficient information may be shared to address an immediate emergency you are facing.

b. Judicial and Administrative Proceedings. We may disclose your personal information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process.

c. Public Health Activities. If we felt you were an immediate danger to yourself or others, we may disclose health information about you to the authorities, as well as alert any other person who may be in danger.

d. Child/Elder Abuse. We may disclose health information about you related to the suspicion of child and/or elder abuse or neglect.

e. Criminal Activity or Danger to Others. We may disclose health information if a crime is committed on our premises or against our personnel, or if we believe there is someone who is in immediate danger.

f. National Security, Intelligence Activities, and Protective Services to the President and Others. We may release health information about you to authorized federal officials as authorized by law in order to protect a national or international figure, or in cases of national security.

g. Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements. The minimum necessary information will be provided in these instances.

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h. Business Associates. Autism & Anxiety Therapists Inc. may disclose the minimum necessary health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.

i. Research/Supervision. Under certain circumstances, Autism & Anxiety Therapists Inc. may use and disclose health information for research and/or supervision. Before we do so, the project will go through a special approval process that includes a consent form for clients to sign if they are included in the research study/supervision. Even without the special approval, however, Autism & Anxiety Therapists,Inc. may permit researchers affiliated with the practice to look at non-identifying information to help them plan research projects.

j. Marketing. Autism & Anxiety Therapists Inc. may send you newsletters or information about services we provide in which we feel you might be interested. You may at any time request that your name be removed from our mailing list. We will not disclose any information to a third party for their use in telemarketing, direct mail marketing, or marketing through electronic mail.

k. Fundraising/Activities. Autism & Anxiety Therapists Inc. may use certain client demographic information-such as your name and address-to contact you about fundraising, ministries, workshops, training events, calendars of events, etc. If you do not wish to be contacted about fundraising, send a written request to Autism & Anxiety Therapists Inc., Attn: Privacy Officer, 1100 Lake Street, Suite 210E., Oak Park, IL 60301.

l. Scheduling Appointments. Autism & Anxiety Therapists Inc. may use your phone number to call you or text you and leave messages to schedule or remind you of appointments.

3. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

a. Right to Inspect and Copy. You have the right to look at or get copies of your health information, with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred.

b. Right to Amend. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We have the right to deny your request under certain circumstances.

c. Right to an Accounting of Disclosures. You have the right to receive a list of instances in which we have disclosed your health information for a purpose other than treatment, payment, or health care operations. To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Such accountings are available for seven years after the last date of service at Autism & Anxiety Therapists,Inc.

d. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you could ask that we not share information with an insurance company, in which case you would be responsible to pay in full for the services provided. To request a restriction after therapy is completed, you must make your written request to the Privacy Officer of Autism & Anxiety Therapists,Inc.. We are not required to agree to your request, but we will consider the request very seriously. If we agree, we will abide by our agreement unless the information is needed in an emergency or by law.

e. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only by mail or at work. You must make this request in writing and it must specify the alternative means or location that you would like us to use to provide you information about your health care. We will make every attempt to accommodate reasonable requests.

f. Right to Obtain a Paper Copy of this Notice. You have the right to receive a paper copy of this notice and any amended notice upon request. Copies are available at the office of Autism & Anxiety Therapists,Inc.. Any other uses and disclosures not set out in the information above will be made only with your written authorization. You may revoke a written authorization for release of information at any time. The revocation must be in writing and will

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become effective when it has been received by the Privacy Officer of Autism & Anxiety Therapists Inc., and will only be for disclosures not already completed.
We reserve the right to change our privacy practices provided such changes are permitted by applicable law. Before the effective date of a material change, however, we will change this Notice and make a new Notice available to you at our location.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, or you may file a complaint with the U. S. Department of Health & Human Services. To obtain additional information, or to file a complaint with us. We will not retaliate in any way if you choose to file a complaint.

Violation of the Confidentiality law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs. This Notice is effective 04.01.2017

Acknowledgment of Receipt of Notice of Privacy Practices By signing this form, you acknowledge that you have received the Notice of Privacy Practices from Autism & Anxiety Therapists Inc. This notice provides information about the ways in which we may use and disclose your protected health information. We encourage you to read it in its entirety. The Notice of Privacy Practices is subject to change. You may ask us at any time for a copy of the current notice, either in person or by contacting us at the number or addresses above. I acknowledge that I have received the Notice of Privacy Practices.

I, _____ have received a copy of the Privacy Practice Notice (pages 1-3), and have read it in its entirety.

Signature _____ Date _____

Parent/Guardian Signature (if necessary)_____ Date_____