Carlos Durana, Ph.D., M.Ac., Lic. Ac.

Mailing Address: 2265 Cedar Cove Court - Reston, VA 20191 - 703-716-0906 - 703-620-0420 (Fax)

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully. Protected Health Information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with me. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services. I am required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Health Information Rights

Inspect and Copy: You have the right to inspect and copy the protected health information that I maintain about you in my designated record set for as long as I maintain that information. This designated record set includes your medical and billing records, as well as any other records I use for making any decision about you. Any psychotherapy notes that may have been included in records I received about you are not available for your inspection or copying by law. I may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing. You may mail in your request, or bring it to my office. I will have 30 days to respond to your request for information that I maintain at my practice site. If the information is stored offsite, I am allowed up to 60 days to respond but must inform you of this delay.

Request Amendment: You have the right to request that I amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request. I will respond in writing within 60 days of your request.

I am permitted to deny your request if it is not in writing or does not include a reason to support the request. I may also deny your request if:

- The information was not created by me, or the person who created it is no longer available to make the amendment;
- The information is not part of the record which you are permitted to inspect and copy:
- The information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

I will respond within 60 days, in writing, explaining if the request was accepted or denied.

Request An Alternative Means of Confidential Communication: You have the right to ask me to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform me in writing as to how you wish to be contacted if other than the address/phone number that I have on file. I will follow all reasonable requests.

Request a Restriction of Your PHI: This means you have the right to ask me, in writing, not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. If I agree to the requested restriction, I will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, I may deny your request for a restriction. You will have the right to request, in writing, that I restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. I am not permitted to deny this specific type of requested restriction.

An Accounting of Disclosure: You have the right to request a list of the disclosures of your health information I have made outside of my practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates greater than six years (my legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, I may charge you a fee for the costs of providing the subsequent list. I will accommodate all reasonable requests.

A Paper Copy of This Notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by calling and asking me to mail you a copy.

File a Complaint: If you believe your privacy rights have been violated you may file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint. If you have any questions about this Notice, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me:

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carlosdurana@caringapproach.com

703-716-0906

Authorize Other Use and Disclosure: You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, I would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if I intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or my practice, has taken an action in reliance on the use or disclosure indicated in the authorization.

I may contact you to provide information about health-related benefits and services offered by my office, for fundraising activities, share information in a disaster relief situation, include your information in a hospital directory, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Ways in Which I May Use and Disclose Your Protected Health Information

The following paragraphs describe different ways that I use and disclose your protected health information. I have provided an example for each category, but these examples are not meant to be exhaustive. I assure you that all of the ways I am permitted to use and disclose your health Information fall within one of these categories.

Treatment: I will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. I will also disclose your health information to other physicians who may be treating you. Additionally -- I may from time to time disclose your health information to another physician whom I have requested to be involved in your care. For example -- I should disclose your health information to a specialist to whom I have referred you for a diagnosis to help in your treatment.

Health Care Operations: I will use and disclose your protected health information to support the business activities of my practice. For example – I may use medical information about you to review and evaluate my treatment and services or to evaluate my staff's performance while caring for you. In addition, I may disclose your health information to third-party business associates who perform billing, consulting, or transcription services for our practice.

Payment: I will use and disclose your protected health information to obtain payment for the health care services I provide you. For example -- I may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Other Ways I May Use and Disclose Your Protected Health Information

Public Health: I will use and disclose your protected health information in certain situations to help with public health and safety issues. Some of the situations include:

- Preventing disease;
- Helping with product recalls;
- Reporting adverse reactions to medications;
- Reporting suspected abuse, neglect, or domestic violence; or
- Preventing or reducing a serious threat to anyone's health or safety.

Research: I will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law: I will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

Other Permitted and Required Uses and Disclosures: I am also permitted to use or disclose your PHI without your written authorization for the following purposes:

- To comply with Food and Drug Administration requirements;
- Legal proceedings;
- Coroners;
- Funeral directors;
- Organ donation;
- Criminal activity;
- Military activity;
- National security;
- Worker's compensation;
- When an inmate is in a correctional facility; or
- If requested by the Department of Health and Human Services in order to investigate or determine my compliance with the requirements of the Privacy Rule.

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 us 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.

By signing this form you acknowledge you were advised of the HIPAA Notice of Privacy Practices. My HIPAA Notice of Privacy Practices provides information about how I may use and disclose your protected information. I encourage you to read it in full. My Notice of Privacy Practices is subject to change. You may request a copy of the Notice of Privacy.

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Signature of Responsible Party Date