

Notice of Privacy Practices- Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

This practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full NPP, which you may request at any time.

We will use the information about your health, which we get from you or from others mainly to provide you with treatment (psychotherapy), to arrange payment for our services, and for some other business activities, which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use your information. If you do not consent and sign this form, we cannot treat you.

If you or we desire to use or disclose (send, share, release, receive) your information for any other purposes we will discuss this with you and ask you to sign a Release of Information form to allow us to do that.

Of course we will keep your health information private, but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. As required by law: Federal, State or Local Law.
5. For Workers Compensation and similar benefit programs.

There are some other situations like these but do not happen very often. They are described in the longer version of the NPP.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can ask us to communicate with you about your health and related issues in particular way or at a certain place, which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care of the payment of your care, such as family members and friends. We do not have to agree to your request. However, if we do agree, we will keep your agreement, except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records, but not Psychotherapy Notes. You can obtain a copy of your records, but we may charge you. Contact our Privacy Officer to arrange how to see your records.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and sent it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP, we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please advise. The effective date of this notice is 1/02/20

PRIVACY PRACTICES ACKNOWLEDGEMENT

**CENTER FOR REVOLUTIONARY RELATIONSHIP, LLC
3200 W. MARKET ST., ST. 101
FAIRLAWN, OHIO 44333**

ACKNOWLEDGEMENT FORM

I received the Notice of Private Practices and I have been provided an opportunity to review it.

Name _____ **Birthdate** _____

Signature _____ **Date** _____