Notice of Privacy Practices

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

You have the following rights in relation to Protected Health Information maintained by The Eating Disorder Trap/ Robyn L. Goldberg, RDN, CEDRD-S:

- **Confidentiality of Your Protected Health Information.** We are required by law to protect your health information from being made available or disclosed to any unauthorized person(s) or process(es).
- **See or Copy Your Protected Health Information.** You have the right to see or copy your health information. If you are requesting paper copies of records or are requesting records to be provided on a compact disc or external storage device, you may be charged a reasonable fee to cover the costs of the materials required and any applicable mailing costs. Copies will be provided to you as soon as possible, but no later than 15 days following the request. We are not required to allow you to see or copy progress notes or information prepared for use in legal actions or proceedings.
- **Request an Amendment to Protected Health Information**. You have the right to request an amendment to your protected health information as long as it is maintained by us. Your request must be in writing and must include the reason why you believe a change should be made. We will respond to your request within 60 days of receipt of the form notifying you if we approve your request or explaining the reason(s) for our decision if we deny your request.
- **Receive an Accounting of Disclosures of Health Information.** You have the right to request a listing of disclosures of your Protected Health Information that we made in compliance with state and federal law. This list will include the person or organization the information was disclosed to, the reason for the disclosure, the date of the disclosure, and a brief description of the information that was disclosed.
- **Request a Restriction of Uses and Disclosures.** You have the right to request a restriction on how we use or disclose your Protected Health Information for purposes of Treatment, Payment, or Operations. If you would like to request a restriction, we will provide you with a Request for Restriction of Use and/or Disclosure Form.
- **Receive a Paper Copy of This Notice.** You have the right to request a copy of this notice upon request at any time.
- **Right to Request Alternative Confidential Communication.** You have the right to request to be contacted in a particular manner; for example, you may request that we contact you using your workplace phone number and do not contact you at your home phone number.
- **Be Notified of a Breach.** We are required to notify you if we are aware of a breach involving your protected health information, as defined by 45 CFR § 164.400-414.
- **File a Complaint.** You have the right to file a complaint if you believe any of your or someone else's health information privacy rights have been violated. You may file a complaint by contacting us. You may also file a complaint with the United States Department of Health and Human Services. For more information on filing a complaint with the Department of Health and Human Services
    - Visit: https://www.hhs.gov/hipaa/filing-a-complaint/index.html. There will be no retaliation against you in any way for filing a complaint.

How Your Health Information May be Used without your Written Permission

- **For Treatment.** Exchange of information between healthcare providers external to the facility may occur under the following conditions: Coordination or management of healthcare; consultation between providers related to a client; and referral of a client from one provider to another**.**
- **For Payment.** Protected health information may be released for payment in accordance with HIPAA and state laws and regulations.
- **For Healthcare Operations.**
- **In Response to a Lawful Court Order.** Your protected health information may be released pursuant to a lawful court order.
- **To Prevent a Serious Threat to Health or Safety.** Your protected health information may be released if the release is intended to prevent or lessen a serious and imminent threat to health or safety and the information is being provided to someone who could prevent or lessen the threat.
- **Mandated Reporting.** If we have reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected, or have reason to believe that a child seen in the course of professional duties has been threatened with abuse or neglect and that abuse or neglect of the child will occur, we are required to make a report to county child protective services or law enforcement. We may also be required to make a report in certain circumstances if we have reason to believe that a dependent adult is being abused or neglected.
- **During a Medical Emergency.** If you are experiencing a medical emergency and are unable to provide consent to release information, your health information may be disclosed to the healthcare provider responding to the emergency. Only information necessary to meet the medical emergency will be disclosed.
- **For Oversight Activities.** Your information may be disclosed to authorized representatives of state licensing bodies or the department of health and human Services when either body is undertaking a compliance audit, investigation, review, or enforcement action.
- **As Required by Law.** Your information will be disclosed as otherwise required by law.

Signature and Acknowledgement

By signing this form, you acknowledge that you have received the Notice of Privacy Practices from Centered The Eating Disorder Trap/ Robyn L. Goldberg, RDN, CEDRD-S. 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 full.

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 via phone or e-mail.

By signing below, you acknowledge that you have received the Notice of Privacy Practices.

_____	_____	_____
Client Name	Signature	Date
_____	_____	_____
Parent/Guardian Name	Signature	Date