NOTICE OF PRIVACY PRACTICES

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

Uses and Disclosures of Health Information

We may use health information about you for treatment (such as sending your records or information to a specialist as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, judicial and administrative proceedings, research studies, funeral arrangements and organ donation, workers' compensation purposes, specialized governmental functions, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also initiate a face–to–face communication with you about goods and services related to your care. We may also contact you about appointment reminders or treatment alternatives. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change your notice and post the new notice in the waiting area. We can also request a copy of our notice at any time. For information about our privacy practices, contact the person listed below.

Individual Rights

In most cases you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies we will charge you $0.05 (5 cents) for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide

you with the appropriate address upon request. Under no circumstance will you be retaliated against for filing a complaint.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practice, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Connections Counseling Services
Chris Hughes, Owner
4190 Highland Drive, Suite 200
Holladay, UT 84124
(801) 272–3420

Acknowledgement

By signing below, I acknowledge that I have received Connections Counseling Services' Notice of Privacy Practices and have been offered an opportunity to request restrictions on certain uses and disclosures of my protected health information.

Signature of client
or parent/guardian: ____ Date: ____________
Typing your name here constitutes an electronic signature and is legally binding.

Relationship to client: ____