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NOTICE OF PRIVACY PRACTICES

Federal legislation requires that I issue this official notice of my privacy practice. You have the right to the confidentiality of your health information and to know how this office can disclose this information and how you can get access to records. If you have any questions I will be happy to answer them.

Your protected Health Information (PHI) which is any information that will identify you and refer to your past and present mental health condition, will be used to carry out treatment, obtain payment from your insurance company and for other purposes that are permitted or required by law.

I am required by law to abide by the terms of this notice. I may change the terms of the notice at any time, as long as you are provided with a written notice of change.

When you sign this document, you give me permission to disclose PHI information in the following circumstances:

Disclosures Requiring Written Consent

Information will be disclosed to third parties with your expressed written consent. I may request that you sign a consent form to obtain/release information from/to other mental health care providers who have treated you or are currently treating you. Other examples of such disclosures may include contacts with primary care physicians as well as schools and other related services and institutions. You may revoke such authorization at any time by notifying me in writing.

Payment

Your PHI will be used as needed to obtain payment for your health care services. This may include any activities that your health insurance plan may undertake before it approves or pays for the health care services I recommend for you or for making a determination of eligibility or coverage for insurance benefits.

In the following instances I do not need your consent to disclose PHI:

Emergencies

I may need to release information in an emergency situation as allowed by law. I would try to get your consent before doing so, or as soon as possible following the incident.

Required by Law

Disclosure will be made as required by law and limited to the relevant requirements of the law. You will be notified by law of any such disclosures. This includes, but is not limited to reports of child abuse or neglect or domestic violence, or for law enforcement purposes such as in response to a court.

Criminal

In the event that a crime occurs on the premises, or if I believe disclosure is necessary to prevent or lessen a serious or imminent threat to the safety of a person or the public.

Your Rights:

You have the right to inspect your file. You must submit a written request to me, and I will give you an appointment to review your file within thirty days. You have the right to challenge the accuracy of your record and you may require that a brief statement by you be placed permanently in your record. You have the right to file a complaint with the Secretary of Health and Human Services if you believe your privacy rights have been violated. You will not be subject to retaliation if you make such a complaint. You may write or call:

Office for Civil Rights
US Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

OCR Hotline:(800)368-1019

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.