TNS

TRIANGLE NEUROPSYCHOLOGY SERVICES, PLLC
3310 Croasdaile Drive, Suite 400, Durham, NC 27705
1540 Sunday Drive, Suite 200, Raleigh, NC 26707

PRIVACY POLICY

PURPOSE: This practice applies the Health Insurance Portability and Accountability Act (HIPAAA) in order to protect the privacy of personal healthy information and to provide secure storage of such information. This is information that relates to the past, present, and/or future physical or mental health condition of a patient. This includes information that relates to the past, present, and/or future health care that is provided to a patient. This includes personal information that could reasonably be used to identify a patient. This includes all information transmitted in any medium.

RIGHT TO PRIVACY/CONFIDENTIALITY: All communication between the patient and the doctor and/or social worker becomes part of the clinical record. Records are the property of Triangle Neuropsychology Services, PLLC. In accordance with legal requirements, the patient records are shredded and disposed of after seven years.

While most communication between the patient and the doctor and/or social worker is confidential, the following limitations and exceptions do exist:

- The doctor and/or social worker determines that the patient is a danger to himself/herself or someone else.
- The patient discloses abuse, neglect, or exploitation of a child, elderly or disabled person.
- The patient authorizes the doctor and/or social worker to release records.
- The referral source request the release of records.
- The patient has a medical emergency while at this practice.
- The doctor and/or social worker is mandated to disclose information. [This includes authorization under the HIPAA Privacy Rule Section 164.512 when disclosure is mandated by law enforcement agencies, to a coroner or medical examiner, by Public Health offices relating to diseases or FDA-regulated products, for specialized government functions (such as fitness for military duty, VA benefits, and/or national security issues), or to a health oversight committee (such as the US Department of Health and Human Services or a state department of health).]

YOUR RIGHTS REGARDING PERSONAL HEALTH INFORMATION: You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Office Manager.

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances,to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained clinic notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Office Manager if you have any questions.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of yourPHI for treatment, payment, or health care operations. We are not required to agree to your request unless therequest is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations,and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Confidential Communication. Normally, we send information related to your healthcare to the address and phone numbers you have provided. However, you have the right to request that your healthcare information be to an alternative address in order to protect confidentiality. You may do so by completing our form to request confidential communication.

BREACH NOTIFICATION: This practice conducts quarterly assessments in order to keep office policies in line with the privacy and security specifications as defined by HIPAA and the American Psychological Association. If the practice becomes aware or suspects a breach of patient information, the practice will conduct a risk assessment and keep a written record of that risk assessment. Unless the practice determines that there is a low probability that personal health information has been compromised, the practice will give notice of the breach. In the event of a breach, the practice will re-assess its privacy and security practices to determine what changes should be made to prevent the recurrence of such breaches.

EMERGENCIES

During office hours, the patient can contact the doctor and/or social worker on the office phone: 919-384-9682. In the event of an emergency that is not during office hours, the patient may call the office phone and receive further contact information through the voice-mail. If the patient is unable to reach his/her psychologist or doctor and/or social worker in a timely manner, the patient should contact his/her physician, a local emergency room, or a local police department when necessary. Also, the patient may contact a local 24-hour help-line (numbers listed below). It is the patient's responsibility to seek the appropriate resources in emergency situations.

If you have any questions, please speak with our Office Manager. Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

_____ _____

Signature of Patient** or Legal Representative** Date

_____ _____

Relationship to Patient*** Signature of Witness

***If you are signing this form on behalf of the Patient, you must state your relationship to the patient. If you are the Health Care Power of Attorney for a Patient, you must provide legal documentation to this effect.

**If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, legal guardian, or other person acting loco parentis who has the authority to act on the minor-Patient's behalf. By signing this form for someone else, you as the parent, legal guardian, a party acting as loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

DURHAM CRISIS RESPONSE CENTER (24-hour referral and assistance) – 919-403-6562