Ascendance Therapy
Mandy Snider, M.Ed., AMFT

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.

This notice gives you information required **by law** about the duties and privacy practices of **Mandy Snider, M.Ed., AMFT** (your therapist) to protect the privacy of your personal health information. Your therapist provides you with behavioral health services. Your therapist receives and maintains your personal health information in the course of providing these health services to you, your therapist may contract with companies or individuals to help provide these services to you. These contractors may receive and maintain your personal health information.

The effective date of this notice is _____ (today's date). Your therapist is required to follow the terms of this notice until the notice is replaced. Your therapist reserves the right to change the terms of this notice at any time. If your therapist makes changes to this notice, your therapist will revise it and send a new notice to all clients. Your therapist reserves the right to make new changes apply to all your personal behavioral health information maintained by your therapist before and after the date of the new notice.

Limits to Confidentiality

1. **Health Care Providers' Treatment Purposes:** Your therapist may disclose your personal health information to your doctor, at the doctor's request, for treatment.
2. **Payment:** Your therapist may use or disclose your personal health information to provide eligibility information to your doctor when you receive treatment, to pay for claims for covered health care services, or to recover costs from other medical insurance or probate estates.
3. **Health Care Operations:** Your therapist may use or disclose your personal health information (a) to conduct quality assessment and improvement activities; (b) to review applications for services; (c) to engage in care coordination or case management; (d) to manage, plan, or develop services and budget; (e) to coordinate services with another public benefit program; or (f) to cooperate with state and federal auditors.
4. **Health Services:** Your therapist may contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.
5. **As Required by Law:** Your therapist may disclose your personal health information necessary to comply with workers' compensation or other laws. Your therapist may also be required to disclose personal health information about abuse, neglect, or domestic violence to governmental or social services agencies.
6. **For other reasons:**
    - To comply with legal proceedings, such as a court or administrative order or subpoena;
    - To law enforcement officials or to correctional institutions for limited law enforcement and health and safety purposes;
    - With your written authorization, to a family member, friend or other person, to help you with your health care or payment for your health care;
    - To your personal representative appointed by you or designated by law;
    - For research purposes in limited circumstances and where the information will be protected by the researchers;
    - To a coroner, medical examiner, or funeral director to identify a deceased person or to arrange payment benefits;
    - To an organ procurement organization in limited circumstances;
    - To avert a serious threat to your health or safety of the health or safety of others;
    - To a governmental agency authorized to oversee government health care programs;
    - To federal officials for lawful national security purposes;
    - To public health authorities for public health purposes;
    - To appropriate military authorities, if you are a member of the armed forces.

Uses and disclosures with your permission: Your therapist will not use or disclose your personal health information for any other purposes unless you give your therapist your written authorization to do so. In most cases, you may revoke your written authorization at any time, unless your therapist has relied upon your authorization for a continuing disclosure, for example, for a research study. Your revocation will be effective from the date of the revocation forward, for all your personal health information that your therapist maintains. Authorization and Revocation forms are available at Illinois Department of Human Services facilities or offices.

Your rights: You may make a written request to your therapist to do one or more of the following concerning your personal health information that your therapist maintains:

- To put additional restrictions on your therapist's use and disclosure of your personal health information. Your therapist does not have to agree to your request under certain circumstances.
- To have your therapist communicate with you in confidence about your personal health information by a different means or at a different location that your therapist is currently doing. Your request must be in writing specifying the alternative means or location to communicate with you.
- To see and get copies of your personal health information. You may be charged a nominal fee for the copies.
- To correct your personal health information. In some cases, your therapist does not have to agree to your request.
- To receive a list of disclosures of your personal health information that your therapist made for certain purposes for the last 6 years, but not for disclosures made before _____ (today's date).
- To have your therapist send you another copy of this notice.

If you want to exercise any of these rights described in this notice, please contact your therapist and you will be given the necessary information and forms for you to complete and return to your therapist.

Complaints

If you believe your privacy rights have been violated by your therapist, you have the right to complain to your therapist or do the Secretary of the U.S. Department of Health and Human Services. Your therapist will not retaliate against you in you choose to file a complaint.

ACKNOWLEDGEMENT

I, _____ (patient) acknowledge that I have

received a copy of the Notice Regarding Privacy of Personal Health

Information as provided to me by Mandy Snider, M.Ed., AMFT.

_____	_____	_____
Printed name of Client	Signature	Date