



Health Insurance Portability and Accountability Act

Our Commitment to Your Privacy

We value the privacy of your health information. This notice outlines how we may use and disclose your health information and your rights regarding this information.

Our Legal Duty

We are required by federal and state law to protect your health information. We must follow the privacy practices described in this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time, as permitted by law. Changes will apply to all health information we maintain, including information created or received before the changes. You may request a copy of our notice at any time.

Uses and Disclosures of Health Information

We use and disclose health information for treatment, payment, and healthcare operations.

- **Treatment:** We may share your health information with healthcare providers involved in your care.
- **Payment:** We may use and disclose your information to obtain payment for services provided to you.
- **Healthcare Operations:** Your information may be used for quality assessment, performance reviews, training, and accreditation.

Your Authorization

We will not use or disclose your health information for any purpose not described in this notice without your written authorization. You may revoke your authorization at any time in writing.

Family, Friends, and Persons Involved in Your Care

We may disclose your health information to family members, friends, or others involved in your care or payment for your care if you agree. In emergencies or if you are incapacitated, we may use our professional judgment to determine what is in your best interest.

Other Uses and Disclosures

- **Marketing Health-Related Services:** We will not use your information for marketing without your written authorization.
- **As Required by Law:** We may disclose your health information if required by law.
- **Abuse or Neglect:** We may report suspected abuse, neglect, or domestic violence to appropriate authorities.
- **National Security:** We may disclose health information to authorized military or federal officials for lawful activities.
- **Appointment Reminders:** We may use your information to remind you of appointments.

Your Rights as a Patient

- **Access:** You have the right to view or obtain copies of your health information, with certain exceptions. Requests must be in writing, and a reasonable, cost-based fee may apply.
- **Disclosure Accounting:** You may request a list of disclosures made for purposes other than treatment, payment, and healthcare operations over the past six years. Additional requests within a 12-month period may incur a fee.
- **Restrictions:** You may request additional restrictions on our use or disclosure of your information. While we are not required to agree, we will comply with any agreed-upon restrictions except in emergencies.
- **Amendments:** You may submit a written request to amend your health information. Requests must explain the reason for the amendment. We may deny your request in certain circumstances.



- **Electronic Notice:** If you receive this notice electronically, you are entitled to request a paper copy.

Questions and Complaints

If you have concerns or believe your privacy rights have been violated, or if you disagree with a decision about your information, you may contact:

Cristine Cappo MA, LPC, LBS, NCC
Private Practicing Clinician
856-886-8402
Theralliance.pa@gmail.com

You may also file a complaint with the U.S. Department of Health and Human Services. We will provide the necessary address upon request. There will be no retaliation if you choose to file a complaint with us or with the Department of Health and Human Services.

Acknowledgment of Receipt

I confirm that I have received the Notice of Privacy Practices. This notice explains how my child's protected health information may be used and disclosed for treatment, payment, healthcare operations, or as required by law, and outlines my rights and responsibilities regarding this information.

Name: _____

Date: _____

X _____
(Parent/Guardian/Patient Signature)