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Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

Heidi Rimer Cherwony, Psy.D., P.A. · Notice of Privacy Practices
Effective Date: December 1, 2026

This notice describes how your Protected Health Information (PHI) may be used and disclosed and how you can access this information. Please review it carefully.

Use and Disclosure of PHI

I use and disclose your PHI for treatment, payment, and healthcare operations.

- **Treatment:** I use your information to provide, coordinate, or manage your healthcare.
- **Payment:** I use your information to obtain payment for services provided.
- **Operations:** I use your information for internal operations, such as quality assessment and administrative tasks.

Limits on Confidentiality

In most situations, I can only release information if you sign a written authorization. However, I am permitted or required to disclose information without your consent in the following circumstances:

1. **Court Proceedings:** Information is protected by psychologist-patient privilege. I cannot provide information without your written authorization or a court order. If I receive a subpoena of which you have been properly notified and you fail to oppose it, I may be required to comply. **If I am subpoenaed or requested to provide testimony, prepare records, or appear in court, the client is responsible for all associated costs, including my professional hourly rate for preparation, travel, and time spent in court/depositions, as well as any reasonable attorney fees incurred by my practice in responding to such requests.** If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. **Oversight:** Government agencies requesting information for health oversight activities.
3. **Defense:** If a patient files a complaint or lawsuit against me, I may disclose relevant information to defend myself.
4. **Worker's Compensation:** If you file a worker's compensation claim, I may be required to submit treatment reports to relevant parties.
5. **Business Associates:** I may disclose information to business associates who perform functions on my behalf, provided they sign agreements to protect your privacy.
6. **Safety/Legal Obligations:** I am legally obligated to report suspected child or vulnerable adult abuse, neglect, or exploitation to the Florida Abuse Hotline. I am also required to disclose information if I believe there is a clear and immediate probability of physical harm to you or others, which may include communicating with potential victims, family members, or the police, or seeking your hospitalization.

Patient Rights

- **Right to Treatment:** You have the right to ethical treatment without discrimination.
- **Right to Confidentiality:** You have the right to have your health information protected.
- **Right to Request Restrictions:** You may request restrictions on certain uses and disclosures of your PHI. I am not required to agree to all requests.
- **Right to Receive Confidential Communications:** You may request to receive communications by alternative means or at alternative locations.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy of your PHI. A copying fee of $1.00 per page applies. Requests must be made in writing and allow 2 weeks for processing.
- **Right to Amend:** You may request to amend your records if you believe they are incorrect or incomplete.
- **Right to an Accounting:** You have the right to receive an accounting of disclosures of your PHI.
- **Right to Terminate:** You have the right to terminate services at any time. I ask that you discuss this with me in a session or by phone.

Therapist Duties

I am required by law to maintain the privacy of your PHI and to provide you with this notice. I reserve the right to change my privacy practices; if I do, I will provide a revised notice in my office.

Complaints

If you believe your privacy rights have been violated, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

Acknowledgment of Receipt

Your signature below indicates that you have read this agreement and agree to its terms, and serves as an acknowledgment that you have received the HIPAA Notice of Privacy Practices.

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name