Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is first in effect on January 1st, 2003

This notice covers all information in our written or electronic records which concerns you, your health care, and payments for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage our administrative operations.

Neuropsychology Associates of Fairfax may use and disclose your protected health information (PHI) for: a. Treatment – i.e.; providing care services, sending information/coordinating care with other health care providers caring for you, ordering and obtaining off site tests/results, etc. b. Payment – i.e.; submitting insurance claims on your behalf for treatment rendered. c. Health care operations – i.e.; internal business planning activities and quality of care evaluation.

Neuropsychology Associates of Fairfax is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization, including, but not limited to: a. Disclosures required by law (ie: court or administrative orders, subpoena, discovery request or other lawful purposes). b. Disclosures to avert any serious threats to your health and safety or the health and safety of another person (ie: if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes) as mandated by law. c. Disclosures with reference to Workers' Compensation or Food and Drug Administration

Neuropsychology Associates of Fairfax may contact the individual to provide appointment reminders or information about treatment or other health related benefits and services that may be of interest to the individual or patient. Neuropsychology Associates of Fairfax will routinely contact patients via telephone at home, cell and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments, test results, etc. We may also send faxes if you have designated this option. Please inform us if you do not what us to leave messages or restrict messages to a specific phone number.

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization at any time.

Our patients have the following rights regarding their protected health information: 1. The right to request restrictions on certain uses and disclosures of PHI. However, we may not agree to all requested restrictions. 2. The right to restrict disclosures to your insurance company for health care items or services for which you have paid for in full at the time of service. 3. The right to receive confidential communications of protected health information, as applicable. 4. The right to inspect and copy protected health information, as provided in the Privacy Regulation. 5. The right to amend protected health information, as provided in the Privacy Regulation. 6. The right to receive an accounting of disclosures of protected health information. 7. The right to obtain a paper copy of the Privacy Notice from the covered entity upon request. 8. The right to file a complaint if you believe your privacy rights have been violated. You will not be penalized for filing a complaint. 9. The right to receive timely notification of any breach of your unsecured protected health information.

Neuropsychology Associates of Fairfax may use or disclose your health information for any purpose based on a signed, written authorization you provide us. Your signed written authorization is always required to disclose your psychotherapy notes if they exist. If we were to disclose your health information for marketing purposes we would require your signed written authorization. In all other cases, we will not use or make a disclosure of your health information without your signed, written authorization, unless the use or disclosure falls under one of the exceptions described in this Notice. When we receive your signed written authorization we will review the authorization to determine if it is valid, and then disclose your health information as requested by you in authorization. You may revoke this written authorization at any time.

Forms to exercise your rights can be obtained from the Office Manager or our HIPAA Compliance Officer.

Neuropsychology Associates of Fairfax is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. Neuropsychology Associates of Fairfax is required to abide by the terms of the Notice currently in effect.

Neuropsychology Associates of Fairfax reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. Neuropsychology Associates of Fairfax will provide individuals or patients with a revised Notice by posting new regulations in the office.

It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

If you have any questions regarding this notice or our health information privacy policies, please contact the HIPAA Compliance Officer, **Mary Beth Quig, Ph.D** at:

Neuropsychology Associates of Fairfax
3020 Hamaker Court, Fairfax VA 22031
(703) 876-0966

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov or call 800-368-1019.

I hereby acknowledge that I have been made aware of the Neuropsychology Associates of Fairfax Notice of Privacy Practices, that a copy is available in the patient waiting room, on the www.neuropsychologyfairfax.com website, or available upon request in the office.

X____

SIGNATURE DATE PRINT PATIENT'S NAME

I AUTHORIZE THE VERBAL RELEASE OF PERSONAL HEALTH INFORMATION RELEVANT TO MY CARE TO THE FOLLOWING INDIVIDUALS: I UNDERSTAND THAT THIS CONSENT WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING:

Name: ____Relationship:_____________________________________

Name: ____Relationship:_____________________________________

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Neuropsychology Associates of Fairfax to release my neuropsychological report to the following recipients:

Name: ____

Agency/Office:____

Address:____

City:_____________________________State:____________Zip: _______________________________

Phone:_______________________________________Fax: _____________________________________

Name: ____

Agency/Office:____

Address:____

City:_____________________________State:____________Zip: _______________________________

Phone:_______________________________________Fax: _____________________________________

Name: ____

Agency/Office:____

Address:____

City:_____________________________State:____________Zip: _______________________________

Phone:_______________________________________Fax: _____________________________________

NEUROPSYCHOLOGY ASSOCIATES OF FAIRFAX USES TESTING MATERIALS THAT ARE PROPRIETARY AND COPYRIGHTED AND PROTECTED BY ETHICS STANDARDS TO MAINTAIN TEST INTEGRITY. RAW DATA AND TESTING MATERIALS CANNOT BE RELEASED TO ANYONE OTHER THAN ANOTHER LICENSED NEUROPSYCHOLOGIST.

X____

SIGNATURE DATE PRINT PATIENT'S NAME