Nick Roselli Occupational Therapy
NR-OT The doctor's choice for personal care and results.

Patient Name:_____**Date**:_____

Patient Privacy Notification Form

How we may use and disclose Health Information about you

In Compliance with the Federal Government's Law (HIPAA) The Health Insurance Portability and Accountability Act of 1996. You the patient are hereby informed of the following Privacy rules in our office.

Treatment

We will use your health information for treatment purposes. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example therapists notes will be available in your medical record to all healthcare professionals who may provide treatment or who may be consulted by staff members.

Payment

We may use and disclose your health information so that treatment that you received from us may be billed to and payment collected from you, an insurance company, or third party. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being provided.

Health Care Operations

Your health information may be used as necessary to support the day-to-day activities and management of NR-OT. For example, information on the services you received may be used to support budgeting, financial reporting, and are necessary to operate our practices and make sure that all patients receive quality care.

Judicial and Administrative Proceedings

We may disclose protected information in response to a court or administrative order. We may also disclose information about you in certain cases in response to a subpoena or other lawful process or as required to do so by law.

Other uses and disclosures that require your authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Expiration Date of Authorization

This authorization iseffective through_____/_____/_____unless revoked or terminated by the patient or the patient's personal representative.

Right to terminate or revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **Nick Roselli – Occupational Therapy.** You should contact Rosalie Bender at (718-454-0842) to terminate this Authorization

Potential for Re-disclosure

Information that is disclosed under this Authorization may be re-disclosed.
The privacy of this information may not be protected under the federal privacy regulations.

To Avert a Serious Threat to Health or Safety

We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety, or the health and safety to the public or another person.

Persons Authorized to use or disclose information

Information will be used or disclosed by:

Nick Roselli—Occupational Therapy and Staff
Name of Person/Organization

Persons to whom information may be disclosed

Information described above may be disclosed to:

_____
Name of Person/Organization

Rights of the Individual

- You may inspect or request a copy of information that is used or disclosed under this Authorization.
- The right to amend or submit corrections to your protected health information.
- The right to receive a printed copy of this notice.
- The right to inspect and copy your protected health information
- The right to an accounting of disclosed information.
- The right to restrict the use of protected health information and to receive confidential communications.
- You have the right to revoke authorization at any time.

Name of Patient (print or type)_____

Signature of Patient: _____

Date:_____

Signature of Patient Representative:_____

Relationship of Patient Representative to Patient:_____