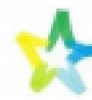

North Star Therapy, PLLC
Arezoo Khanzadeh, Psy.D. LCP
3516 Plank Road, Suite 6C
Fredericksburg, VA 22407
P: 540- 388-2891 F: 540-412-0223

Patient Name:_______________________________ Patient Date of Birth: ___________________

HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information. Signing this form, you are agreeing with the fees (as discussed in the initial session), assignment of benefits, and giving North Star Therapy, PLLC (NST) permission to release your Personal Health Information (PHI) for the following three reasons:

1. Treatment—with outside providers (PCP, specialists involved with your treatment, etc.)
2. Payment—minimal information is provided to your insurance necessary for treatment approval, payment authorization, and billing according to your insurance policy.
3. Standard office practice—record keeping, scheduling appointments, phone calls, required audits, and administrative services.

Any other releases of PHI require your written permission. Exceptions:

- To report abuse, neglect and domestic violence
- To avert a serious threat to the health and safety of a person or the public
- In response to subpoenas and other requests to provide information for court or administrative proceedings
- To HHS to demonstrate HIPAA compliance
- As required by other laws
- Licensing board investigations

NOTE: When PHI is disclosed or used, the Privacy Rule requires psychologists to share the minimum amount of information necessary to conduct the activity.

<u>What are your rights?</u>

- Put restrictions on disclosures
- Request that we send confidential information to alternate locations to protect your privacy · Receive a list of disclosures made (i.e. billing, outside providers, etc.)
- To request and receive a full copy of the privacy policy
- To submit a request to inspect, copy or amend your records

<u>How do I file a complaint with HHS?</u>

- You may go online: http://www.hhs.gov/hipaa click on “filing a complaint”

I, Dr. Arezoo Khanzadeh, am committed to maintain the privacy of your PHI and will notify you of any changes in our privacy policies and practices. Please note that under HIPAA, Dr. Khanzadeh has the right to deny your request to inspect, copy, or amend your records, but will make every reasonable effort to discuss this with you (this action would be conducted to prevent more harm to the individual).

By signing this form, I have been informed of my HIPAA privacy and at any time will be provided a copy upon request.

____
Patient/Guardian signature & Date

____
Arezoo Khanzadeh, Psy.D. & Date