



Notice of Privacy Practices

Use and Disclosure of Your Health Information

For Treatment- Your PHI may be used and disclosed by those involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members.

For Payment - PHI may be used or disclosed to receive payment for the services provided to you. Examples include making a determination of eligibility or coverage of insurance benefits, processing insurance claims, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only necessary PHI for payment will be disclosed.

For Health Care Operations - Your PHI may be used or disclosed to support business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, PHI may be shared with third parties that perform business services related to your treatment

For Legal Compliance - Under the law, disclosures to you about your PHI may be provided at your request. In addition, disclosures may be made to the secretary of the department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule,

Without Authorization - The following categories allow for disclosure of PHI without an authorization; abuse and neglect, emergencies, judicial and administrative proceedings, law enforcement, national security, public safety (duty to warn).

Verbal Permission - With your verbal permission, disclosure of PHI may be made to family members that are directly involved with your care.

With Authorization - Use and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights

You have the following rights regarding your personal PHI maintained by this office. To exercise any of these rights, please submit a written request to your therapist:

To inspect and Copy - You have the right, which may be restricted in specific circumstances, to inspect and copy PHI that may be used to make a decision about your care. Your right to access your PHI will be restricted only in those situations where there is compelling evidence that access would cause harm to you. I may charge a reasonable, cost-based fee for copies.

Right to Amend - If you feel that the PHI on record about you is incorrect or incomplete, you may request to correct or amend, although I am not required to agree to such amendment.



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Right to Accounting of Disclosures - You have the right to request an accounting of certain disclosures of your PHI. Right to Request Restrictions- You have the right to request a restriction or limitation of the use or disclosure of your PHI for treatment, payment, or health care operations, although I am not required to agree to your request.

Right to a Copy of This Notice - You have a right to a copy of this Notice.

Acknowledgment of Receipt of Notice of Privacy Practices for Protected Health Information (PHI)

I have had the opportunity to review the Notice of Privacy Practices of Dannel Wissler, LPC. I understand that the terms of this Notice may change from time to time, in which case I will be notified of such changes, either verbally or in writing.

I understand that I have the right to request to restrict the use and disclosure of PHI for carrying out treatment, payment, and/or health care operations. I understand that Dannel Wissler, LPC is not required to agree to any restriction, and that treatment may be conditional upon signing of this Consent.

I understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that Dannel Wissler, LPC has acted in reliance hereon.

By my signature below, I give my consent for Dannel Wissler, LPC to use and disclose, for the purpose of carrying out treatment, payment, and/or health care operations, protected health information (PHI) in reference to:

I have read and I agree to Notice of Privacy Practices

Signature of Client or Legal Guardian

DOB

Date

Sign Full Name

MM-DD-YYYY

MM-DD-YYYY

DANNEL WISSLER, LPC CAADC

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