PEDIATRIC SCHOOL PSYCHOLOGY:
EVALUATION AND CONSULTATION SERVICES, LLC
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Notice of Privacy Practices:

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

In compliance with the Health Insurance Portability and Accountability Act (US Public Law 104-91 or *HIPAA*), all staff members of *Pediatric School Psychology: Evaluation and Consultation Services, LLC* have been trained in health information privacy practices and are committed to providing for the confidentiality and security of your protected health information or PHI. Your PHI is any information that may reasonably allow someone to identify your child. PHI includes such things as:

Name	Phone numbers	Dates of service
Address	E-mail addresses	Payment information
Birthdate	Social security number	Photos

This office maintains records of each visit you make for evaluation or consultation services for the purposes of establishing diagnoses, response to treatment or intervention, and planning for future care. This documentation improves your care and allows for communication with other entities involved in your/your child's care. From time to time, data collected from records reviews may be used in research, but no identifying information will be disclosed if this research is submitted for publication.

Our Responsibilities: 1) To protect the privacy of your PHI according to the law's requirements. 2) To provide you with a current copy of our Notice of Privacy Practices. **Your PHI will be not be provided to anyone else without your written permission.** The law provides for certain exceptions including: disclosures for law enforcement purposes, to avert a serious threat to health or safety and when there is evidence of abuse, neglect, or domestic violence.

Your Rights: 1) You have the right to inspect and copy your protected health information. *Staff members' notes about information provided in confidence that relates to counseling of families or children are afforded special privacy under the HIPAA regulations and are excluded from this right*. If you request additional copies of reports following the initial distribution of the evaluation and/or intervention reports, *Pediatric School Psychology: Evaluation and Consultation Services, LLC* reserves the right to charge you for the copies, the office staff time required to locate and copy the documents, and for the postage. 2) You have a right to receive a history of disclosures of protected health information. 3) You have the right to restrict the use of your protected health information and to revoke prior authorizations allowing release of such information. 4) You have the right to request changes to your PHI. 4) You have the right to obtain a paper copy of this notification. 5) You have the right to complain to the Secretary of Health and Human Services if you feel that your privacy rights have been violated. Additional copies of this form are available from this office by calling 803.309.5231 or emailing: betsygrier@aol.com.

By signing this form, I acknowledge that I have read and understand the privacy policy of *Pediatric School Psychology: Evaluation and Consultation Services, LLC* and have been given a copy of this information. I understand that I can revoke any signed permissions for release of information at any time by providing written notification of this revocation.

Print Name:_____ Signature _____Date_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patient's Name: _____

Relationship to Patient: _____