

## Notice of Patient Privacy Practices and Rights

Name of Practice:    E3 Possibilities, LLC

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This notice describes how medical information about you may be disclosed and used, and how you can get access to this information. Please read carefully.

**Your basic rights and our basic responsibilities under HIPAA.** Patients of this practice have the right to obtain a copy of paper or electronic medical records, make corrections to the record, request confidential communication, request that we limit the information we share, get a list of entities with whom we have shared your information, get a copy of this notice, choose someone to act on your behalf, and file a complaint if you believe your privacy rights have been violated.

**Get a copy (paper or electronic) of your records.** We will provide a copy of your record, and can charge you a reasonable, cost-based fee.

**Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incomplete or incorrect.

**Request preferred confidential communications.** You can ask us to contact you by a preferred method ( ie. Home/office/cell) or ask to send mail to a specified address.

**Limit what we share or use.** You can ask us not to share or use certain health information for our operations, treatment or payment, although we are allowed to refuse your request if it would affect your care. If you pay for a service out of pocket in full, you can ask us not to share that with your health insurer, and we will comply unless a law requires us to share that information.

**Get a list of those with whom we have shared information.** Upon request you are entitled to receive a list of the times we have shared your health information, who we shared it with, and why for up to six years prior to the date you asked. We will include all the disclosures except those about treatment, payment and health care operations, and certain other disclosures, such as any you requested. There is no charge for a yearly request of this list, but there is a reasonable cost based fee if such list is requested more than once in a 12 month period.

**Get a hard copy of this privacy notice.** Upon request, you can receive a paper copy of this notice, if you have previously received this electronically.

**Choose someone to act on your behalf.** If someone is your legal guardian, or has medical power of attorney for you, that person can exercise your rights and make choices about your healthcare information. We will verify that any person has the authority to act on your behalf before taking any action.

**File a complaint if you think your rights are violated.** If you feel your rights have been violated, please contact us (info on page 1). You can file a complaint with the US Dept of Health and Human Services Office of Civil Rights by visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/), calling 877.696.6775 or writing to: US Dept of H and H Services, Office of Civil Rights, 200 Independence Avenue, S.W. Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

**Your Basic choices and our basic responsibilities under HIPAA.** For certain health care information, you can tell us your choices about what we share. You can tell us whether to share information with your family, close friends, others involved in your care. You can tell us whether to share information in a disaster relief situation. We will never share your information for the sale of the information or for marketing purposes unless we have express written permission. We can contact you in the case of fundraising, but you can tell us not to contact you again.

**Our use and disclosures of your health information to treat you, run our practice or bill for your services.** We may use and share your health information to treat you and share with others who are treating you. Ex – a

child being treated by multiple therapists and disciplines. We can use and share your health information to run our practice, improve your care and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities. Ex- we give information to your insurer so they will pay for our services.

**Other ways we may share or use your health information.** We are required (upon request) to share your information in other ways that contribute to the public good, such as public health and research. These conditions are stringent and regulated by many laws before any information can be shared.

**Help with safety and public health issues.** We can share health information about you for certain situations such as preventing disease, helping with product recall, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, preventing or mitigating a serious threat to someone's health or safety.

**Do research.** We can use or share your information for health research.

**Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director.** We can share information upon request when an individual dies.

**Comply with the law, respond to any legal action.** We will share information about you if state or federal law requires it, including any audits conducted by the Dept. of Health and Human Services. We can share information about you in response to a court or administrative order or in response to a subpoena.

**Comply with worker's compensation, law enforcement, other gov't requests.** Information about you can be shared for worker's comp claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

**Blue Button protocol.** Any patients with medical care managed by the Blue Button protocol can learn more about access to their health information at <http://www.hhs.gov/digitalstrategy/open-data/introducing-blue-button-plus.html>

**Summary of our responsibilities.** We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We will give you a hard copy of this notice and follow the duties and privacy practices described in this notice. We will not use or share your information other than as described here unless you tell us we can in writing that we can. You may also change your mind at any time and let us know in writing if you do. Add't info is available at:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Changes to the terms of this notice.** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website and in our office.

**Effective date:** 10/13/2022

**Privacy Officer:** Adrienne King, MS, OTR/L



## PATIENT INFORMATION CONSENT FORM

I have read and understand this practice's **Notice of Patient Information Practices**. I understand that the practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company. I also understand that the Company will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Company's **Notice of Patient Information Practices**. In doing so, I hereby release

\_\_\_\_\_ from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the Company in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

Patient and Parent/Guardian's Printed Name if Patient is under 18

\_\_\_\_\_  
\_\_\_\_\_

Signature

Name of Covered Entity: E3 Possibilities, LLC

Name of Business Associate: Adrienne King, MS, OTR/L

## Obligations and Activities of Business Associate

- a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
- b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
- d. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- e. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a time and manner or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- f. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

## Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

- a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).
- d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 164.502(j)(1).

## Obligations of Covered Entity

## Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

- a. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
- b. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

## Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity except if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate

## Term and Termination

- a. Term. The Term of this Agreement shall be effective as of \_\_\_\_\_ and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement
  2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
  3. If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.
- b. Effect of Termination.
    1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
    2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon [Insert negotiated terms] that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or

destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Miscellaneous

- a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
- c. Survival. The respective rights and obligations of Business Associate under Section [Insert Section Number Related to "Effect of Termination"] of this Agreement shall survive the termination of this Agreement.
- d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

Date \_\_\_\_\_

Signature \_\_\_\_\_