Thrive
Healing Center for Children & Families
2542 S. Bascom Ave. Suite 125, Campbell CA 95008
408.963.6437 ph 408.963.6594 fax thrive-hcfc.org

Description of Privacy Practices

This is a summary of my clinic's privacy practices, describing how medical information about you is used and disclosed and how you can get access to this information. If you would like more information, please feel free to discuss these matters with me personally. You can also read about The Health Insurance Portability and Accountability Act (HIPPA), which is legislation that governs the electronic transfers of health data. This information can be found on the Internet at https://www.hhs.gov/hipaa/for-individuals/medical-records/index.html

You have the following rights regarding your medical information:

1. You may inspect and obtain a copy of your medical records

2. You may add an addendum to or correct your medical records

3. You may request an "accounting of disclosures" of your medical information that documents any releases of your medical information

4. You may request restrictions on certain uses of disclosures of your medical information

5. You may request that we communicate with you in a certain way or at a certain location.

6. You may request a full written version of the privacy practices

My disclosures of your medical information will be only for the following purposes:

1. To provide you with medical treatment and services

2. To bill and receive payment for the treatment and services you receive

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3. For functions necessary to run the clinic and to assure that all patients receive quality care

4. As required or permitted by law

In certain situations, I may disclose your medical information without your authorization, including:

1. For worker's compensation or similar programs

2. For public health activities (e.g. reporting abuse or reactions to medications)

3. To a health oversight agency, such as the California Department of Health Services

4. In response to a court or administrative order, subpoena, warrant or similar process

5. To law enforcement officials in certain limited circumstances

By Signing this form you acknowledge that you received a Notice of Privacy Practices from AnaMaria Guevara, LCSW. That notice explains how I may use the personal health information that I maintain about you in my practice.

Signature: _____

Date: _____

Printed Name: _____

If other than the client, specify relationship _____