Dr. Roberta L. Marowitz, LMFT

COUNSELING & RELATIONSHIP INSTITUTE
237 Lookout Place, Maitland, FL 32751
Phone: (407) 865-3855 Fax: (321) 203-2512

Notice of Privacy Practices

This notice describes how medical/psychological information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on October 1, 2019 and remains in effect until we replace it.

The privacy of your information is important to us. We understand that your information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical/psychological information.

The law requires us to:

1. Keep your information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the law permits the changes.
2. Make the changes in our privacy practices and the terms of our notice effective for all information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your medical/Psychological Information: The following section describes different ways that we use and disclose information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose information. We will not use or disclose your information for any purposes not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For treatment: We may use medical information about you to provide you with services. We may disclose information about you to Registered Mental Health Counseling Interns under our supervision for the purpose of education or training, or to professional colleagues for the purpose of case review and treatment planning. However, in these cases, no identifying information is provided.

For payment: We may use and disclose your information for payment purposes.

For Health Care Operations: We may use and disclose your information for our health care operations. This might include measuring and improving quality, conducting training, and getting the accreditations, certifications, licenses, and credentials we need to serve you.

Notification: In case of emergency in scheduling or psychological conditions, we will notify a family member, your personal representative or another person designated by you if you are unavailable or unreachable. We will share only the information that is directly necessary for your care, according to our professional judgment.

Court orders and judicial and administrative proceedings: We may disclose medical information in response to a judicial order, under certain circumstances. Under limited circumstances, we may share your information with law enforcement officials. We may share limited information with a law enforcement official concerning the information of a crime victim or missing person.

Public health activities: As required by law, we may disclose your information to legal authorities charged with preventing injury or harm, including child or elderly abuse or neglect.

Victims of abuse, neglect, or domestic violence: We may disclose information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence. We may share

your information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

Workers' compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health oversight activities: We may disclose information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

You have a right to:

1. Look at and/or get copies of a treatment summary regarding your treatment. State law allows that specific treatment notes need not be supplied. However, you do have the right to review your treatment records in the presence of the therapist or a representative appointed by the therapist. You may request that we provide copies of the treatment summary in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact person listed at the end of this notice. If you request copies, we will charge you $1.00 per page and postage if you want the copies mailed to you. If you wish to have copies faxed to you, or to another person or facility authorized in writing by you, we will charge you $1.00 per page and a transmission fee of $3.00. These fees must be paid prior to the release of information.
2. Receive a list of all times we shared your information for purposes other than treatment payment, health care operations, and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your information by different means or to different locations. Your request that we communicate your information to you by different means or different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change the information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you want to be changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request to the Privacy Officer.

Questions and complaints:
If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the Florida Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Florida Department of Health
Bald Cypress Way
Tallahassee, FL 32399-3260
Privacy Officer: Dr. Roberta Marowitz, LMFT

_____ _____/_____/_____
Signature of Client Date

_____ _____/_____/_____
Signature of Legal Guardian, if needed Date