HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: Chitter Chatter LLC
Name of Healthcare Provider/Physician/Facility/Medicare Contractor
4820 Studbury Hall Ct.
Street Address
Wake Forest, NC 27587
City, State and Zip Code

RE: Patient Name: ______________________
Date of Birth: ______________ Social Security Number: ______________

I, the undersigned, authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with services provided by Chitter Chatter, LLC. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

All physical, occupational and rehab requests, consultations and progress notes.

All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

All employment, personnel or wage records.

All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period ___________ to ___________.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: ________________

____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following:

____

Name of Representative

____

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

____

Street Address

____

City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii):

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

____________________________________ ____________________

Signature of Patient or Legally Authorized Representative Date
(See 45CFR § 164.508(c)(1)(vi))

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Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv))

______________________________________ ____________________

Witness Signature Date

4820 Studburyhall Ct. · Wake Forest · NC · 27587 · P. 919 609 5643 · F. 919 400 4334

Admission Agreement

Patient's Name: DOB: __________

CONSENT FOR SERVICE: I hereby authorize the staff of Chitter Chatter, LLC to conduct speech/language therapy services as ordered by physician and as are included in my plan of care. I understand that Chitter Chatter, LLC will bill my insurance. I understand that it is my responsibility to keep my child's insurance and/or Medicaid coverage in effect. I agree to inform Chitter Chatter, LLC of any changes in my child's insurance coverage. I acknowledge that Chitter Chatter, LLC is not responsible for damage, theft or similar occurrences within my home during the provision of care by Chitter Chatter, LLC.

AUTHORIZATION FOR PAYMENT OF SERVICES:

Medicaid patients:	I certify that the information given by me in applying for payment under Medicaid is correct. I request that payment of authorized benefits be made on my behalf to Chitter Chatter, LLC. I will be financially responsible for services rendered that are not paid by Medicaid.
Private Insurance Patients:	I certify that the information given by me in applying for payment under my insurance is correct. I request that payment of authorized benefits be made on my behalf to Chitter Chatter, LLC. I will be financially responsible for services rendered that are not paid by my insurance.

I further certify that my rights and responsibilities as a patient or guardian of a patient, have been explained to my satisfaction. My plan of care and goals have been explained to me and I concur.

The undersigned agree to be responsible for and pay any obligations of the above patient owed to Chitter Chatter, LLC.

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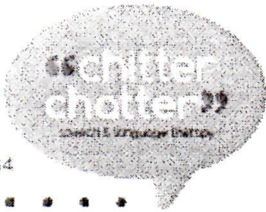
Signature of Responsible Person Relationship Date



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Cancellation Policy

Chitter Chatter, LLC will abide by the cancellation policy as described below:

-if a treatment session is to be cancelled by the family of a patient, notification must be give to the treating therapist **at least 24 hours** in advance of the scheduled appointment.

-in the case of an acute illness or emergency, and it is impossible to give such advanced notice, please call the treating therapist as soon as you realize that you will not be available for the scheduled appointment.

-if your child attends daycare and is served at the daycare center, **this policy applies there as well.** Please alert the treating therapist that your child will not be at the center for his/her scheduled appointment, in accordance with the above described procedures.

Please note, that **if a child misses 3 scheduled treatment sessions** without proper nofication, Chitter Chatter reserves the right to terminate treatment services. Consistency and prescribed frequency of treatment are paramount to each patient's success in therapy.

While we strive as therapists to be consistently punctual, Chitter Chatter **reserves the right to arrive 15 minutes prior to or after scheduled appointment times without notifying the family.** Traffic, previous patients, and unforeseen delays occur with other patients in a traveling daily schedule. We appreciate your patience as we strive to provide quality services.

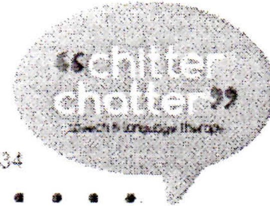
By signing this form, you agree to above described cancellation policy and scheduling of appointments.

____

Signature of Responsible Person   Relationship   Date

____

Patient's name



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ACKNOWLEDGEMENT OF PRIVACY NOTICE AND CLIENT PRIVACY RIGHTS

As a client of Chitter Chatter, LLC, you have rights regarding your child's services and the protection of your child's health care information. A copy of our "Notice of Privacy Practices" has been given to you today. By signing below, you acknowledge receipt of our "Notice of Privacy Practices" and that its' content has been explained to me. If you have any questions, you may call Jenna Thomas@Chitter Chatter, LLC at 919-609-5643.

____

Signature of Responsible Person   Relationship   Date

____

Patient's name

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Release of Information

Patient's Name: ______________ DOB: __________

Parent/Guardian: ______________________________

I hereby give permission for my child's records (summation of all of Chitter Chatter's documentation) to be exchanged between the following individuals, companies, agencies, schools, doctor's offices and/or other professional organizations. I understand that these records will be used only for the purposes of therapeutic, educational and assistive means. Records may include written and verbal information.

(Please check the agencies applicable to the above named patient.

	Physician:	
	Medicaid/Private Insurance:	
	Daycare/Caregiver:	
	CDSA/Service Coordinator:	
	CBRS provider:	
	Occupational Therapist:	
	Physical Therapist:	
	School System	
	Case Manager	
	Other:	
	Other:	

____

Signature of Responsible Person | Relationship | Date

____

Witness Signature | Witness Printed Name | Date

Chitter Chatter, LLC

Notice of Privacy Practices

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

If you have any questions about this Notice, please contact the Privacy Officer.
Jenna Thomas 919-609-5643

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlines in the Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.

Uses and Disclosure of Protected Health Information

1. **Treatment.** Your PHI may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. For example: Your PHI may be shared with home health agencies to provide care for you.
2. **Payment.** Your PHI may be used to seek payment from your health plan, from other sources of coverage, such as an automobile insurer, or from credit card companies that you may use to pay for services. For example: Your insurance company may request and receive information on dates of service, the services provided, and the medical conditions being treated.
3. **Health Care Operations.** Your PHI may be used as necessary to support the day-to-day activities and management of Cornerstone Pediatric & Adolescent Medicine. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality of care within our organization.
4. **Law Enforcement.** Your PHI may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government- mandated reporting.

5. **Public Health Reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Your PHI may be used or disclosed in other ways without your permission:

- Health oversight agencies
- Legal proceedings
- Coroners, funeral directors
- Medical research
- Special government purposes
- Correctional institutions
- Workers Compensation
- Business Associates
- Health Information Exchange
- Fundraising activities
- Treatment alternatives
- Appointment reminders

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in the best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop times of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan symptoms, or prognosis.

All other uses and disclosures not recorded in the Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. You must request form from a staff member and submit to the Privacy Officer or Medical Records for approval.

- **You have the right to see and obtain a copy of your protected health information.**
- **You have the right to request a restriction of your protected health information.**
- **You have the right to request for us to communicate in different ways or in different locations.**
- **You may have the right to request an amendment of your health information.**
- **You have the right to a list of people or organizations who have received your health information from us.**

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:
Jenna Thomas
Chitter Chatter, LLC
4820 Studbury Hall Court
Wake Forest, NC 27587

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was updated on September 23, 2013 according to the Omnibus Regulations.

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

- Please provide us with the phone number(s) that we or an automated service may leave messages regarding appointments:
  - ______________________ ______________________
  - ______________________ ______________________
- Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointment:
  - ____
  - ____
- Please provide us with the name(s) and phone number(s) that we may talk to regarding your treatment and/or results:
  - ____
  - ____
- Please provide an email address that this office may communication health information to you with:
  - ____
- Please provide us with the name and number of your emergency contact:
  - ____

You must inform us in writing of any changes in your directives.

I acknowledge that everything above is accurate.

______________________	______________________	__________
Signature	Printed Name	Date

I acknowledge that I have seen or been offered a copy of the "Notice of Privacy Practices"

______________________	______________________	__________
Signature	Printed Name	Date

____

Relationship to Patient