

**Mariana Cordova, Psy.D.**  
Licensed Psychologist, PY 10579  
**Orange Blossom Psychology, PLLC**  
Phone: 813-438-6709  
Email: [drmariana@obpsychology.com](mailto:drmariana@obpsychology.com)

## **Notice of Privacy Practices**

### **Health Insurance Portability Accountability Act (HIPAA) Client Rights and Therapist Duties**

This notice and agreement contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. You may revoke this Agreement in writing at any time.

### **Limits to Confidentiality**

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary, as determined by me in my good faith discretion. Reasons I may have to release your information without authorization include, without limitation:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or are contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including without limitation, the patient's employer, the insurance carrier, or an authorized qualified rehabilitation provider.

5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment, including without limitation:
  - a. If I know, or have reason to suspect, that a child under the age of 18, or an elderly individual over the age of 65, or a person with a physical or mental handicap, has been abused (i.e., physically, sexually, psychologically, or emotionally), abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the vulnerable individual's welfare, the law requires that I file a report with the Florida Department of Children and Families (DC&F). Once such a report is filed, I may be required to provide additional information.
  - b. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including without limitation communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

### **Client Rights and Therapist Duties**

#### **Use and Disclosure of Protected Health Information:**

1. For Treatment – I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will ask you to sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
2. For Payment – I may use and disclose your health information to obtain payment for services provided to you as delineated in the general Informed Consent. Payment activities include, without limitation, determining your eligibility for benefits and obtaining payment from insurers that may be responsible for providing coverage to you, including federal and state entities.
3. For Healthcare Operations – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records as a quality control measure. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

#### **Patient's Rights:**

1. Right to Treatment – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
2. Right to Confidentiality – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask not to share that information for the purpose of payment or our operations with your health insurer.

3. Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
4. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
5. Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of your PHI. Records must be requested in writing (email suffices) and release of information must be completed. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
6. Right to Amend – If you believe the information in your records is incorrect and/or missing important information, you can ask me to make certain changes to your health information. You have to make this request in writing. You must tell me the reasons you want to make these changes, I will then decide whether or not to make the requested changes, and if I refuse to do so, I will tell you why within 60 days.
7. Right to a Copy of This Notice – If you received this notice electronically, you have a copy in your email. If you completed this paperwork in an office during your first session, a copy will be provided to you per your request, or at any time.
8. Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. Upon your request, I will discuss with you the details of the accounting process.
9. Right to Choose Someone to Act for You – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will confirm that the person identified has this authority and can act for you before I take any action.
10. Right to Choose – You have the right to decide not to receive services with me. At your request, I will make reasonable efforts to provide you with the names of other qualified professionals.
11. Right to Terminate – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
12. Right to Release Information with Written Consent – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

**Therapist's Duties:**

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice at any time. If the terms of the Notice are changed, the new terms will apply to all of your health information, whether created or received by me before or after the date on which the Notice is changed. Any updates to the Notice will be provided to you.

**Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services. You will not be penalized or retaliated against by me for filing a complaint.

By signing this document, you are agreeing that you have read, understood, and agreed to the items contained in this document.

---

Patient or Legal Guardian Name

---

Date

---

Patient or Legal Guardian Signature

---

Date