Felice Block, M.A., LCPC 847-494-0482
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4160 Rte.83 Suite 206
Long Grove, IL 60047

Effective date of this notice is April 14, 2003

HIPPA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed. Please Review it Carefully.

Felice Block, M.A., LCPC is committed to maintaining client confidentiality. I will release healthcare information about you only in accordance with federal and state laws and ethics of the counseling profession. I am the Privacy Officer of my practice so please speak with me if you have any questions

Uses and disclosures of your health information for the purposes of providing services.
Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information for these purposes:

Treatment: I may need to use or disclose health information about you to provide, manage or coordinate your care or related services which could include consultants and referring primary care physicians.

Payment: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. I may bill the person in your family who pays for your insurance.

Healthcare Operations: I may need to use information about you to review our treatment procedures and business activity. Information may be used for certification/ authorization of treatment from insurance or referring medical provider, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent:
There are some instances where I may be required to use and disclose information without your consent. For example, but not limited to:

- Information you and/or your child or children report about physical or sexual abuse, by State of Illinois law, I am obligated to report to the Department of Children and Family Services.
- If you provide information that informs me that you are in danger of hurting yourself or others
- Information shared with law enforcement if a crime is committed on my office premises, against myself, my employees or anyone else
- A subpoena or court order
- For Workers Compensations and similar benefit programs

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HIPPAA PATIENT CONSENT FORM
Required by U.S. Federal Law, effective April 14, 2003

The HIPPA Notice of Privacy Practices form provides you with information about how protected health care information may be disclosed about you. You have the right to review that Notice before signing this Consent. The terms of my Notice may change. If I change the notice, you may obtain a revised copy by contacting my office.

You have the right to request that I restrict how protected health information about you is used or disclosed for treatment, payment or health care operation. Although I will try to respect your wishes, I am not required to agree to this limitation. If I agree to that request, I shall honor that agreement.

By signing this form, you consent to my use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures I have already made in reliance on your prior consent. I provide this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Felice Block, M.A., LCPC has a Notice of Privacy Practices and the patient has the opportunity to review this Notice
- Felice Block, M.A., LCPC reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information but Felice Block, M.A., LCPC does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- You have the right to complain if you believe your privacy rights have been violated, please contact Felice Block, M.A., LCPC
- You may request an accounting of any disclosures, if any, your counselor has made related to your medical information except for information used for treatment, payment or healthcare operations, or information you gave specific written consent to release. To receive information regarding disclosure made within a specific period of time, no longer than six years, please submit your request in writing.

This Consent was signed by:

_____Date:_____
Print Patient's Name

_____Date:_____
Signature of Patient or Representative

Witness:

_____
Printed Name

_____
Signature **Date**