Therapy Connections P.C.
4830 Chestnut Bellaire, Tx 77401
713.839.8255(p) 713.665.7563(f)

NOTICE OF PRIVACY PRACTICES

Therapy Connections P.C. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that *Therapy Connections P.C.* is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that *Therapy Connections P.C.* amend your protected health information. Please be advised, however, that *Therapy Connections P.C.* is not required to agree to amend your protected health information.. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by *Therapy Connections P.C.*
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Request for Alternative communication: mail/phone/fax/email

____

Please initial:
I have read the Privacy Notice and understand my rights contained in the notice. _________
Financial Responsibility:
I understand I am financially responsible for all services rendered. _________
I understand a $30 late cancellation fee (less than 24 hrs) may be applied. _________

By way of my signature, I provide *Therapy Connections P.C.* with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice. I also understand my financial responsibility.

Please release records to: ____

____

____
Patient's Name (print)

____ ______________
Patient's Signature Date

____ ______________
Authorized Facility Signature Date

©H.J. Ross Company, Inc. 2002 HIPAA Interactive-All Rights Reserved updated 06/2013