

The Speech, Language & Learning Center, LLC
www.sllcenter.com

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. You have a right to obtain a copy of this notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. You may ask us to communicate with you confidentially by, for example, using your cell phone number only, or sending mail to a certain address.

Inspect and Obtain Copies: In most cases, you have the right to review or obtain a copy of your health record. There may be a small charge for the copies, if over ten pages are requested.

Amend Information: If you believe that the information in your record is incorrect, or if important information is missing, you have the right to request that we correct or add to the existing information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information and abide by the terms of the notice currently in effect.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You will not be penalized in any way for filing a complaint.

Contact Person:

Terri Flynn
Privacy Officer
PO Box 96
Lawrenceburg, TN 38464

please keep for your records

(11/14)

HIPAA

Permission/Authorization for Release of Private Information

_____ I give my authorization to the staff of The Speech, Language & Learning Center, L.L.C., to discuss any treatment issues concerning me to:

_____ (name and relationship)

_____ I have been given a copy of my rights and the Center's Privacy Policy.

_____ I give my permission for the staff at the SLLC to leave a message on my home answering machine or to any person answering my home phone.

_____ I give my permission for the SLLC staff to contact me at my place of employment.

_____ I give my permission to the SLLC staff to fax any information regarding treatment to my physician's office, or another agency that may be covering our services.

_____ If there is any information I do not want discussed or a message to be left at my home or at my place of employment, I will notify the SLLC staff of this in writing.

Patient Name: _____

Signature: _____

Date: _____

Please complete and mail before your appointment

(11/14)