DIVINE SPEECH AND SWALLOWING SOLUTIONS
Treating People, Not Just The Diagnosis

4631 NW 53rd Ave. Suite 102
Gainesville, Fla 32653
Office: 352-440-8147
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therapy@divinesss.com
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HIPAA Notice of Privacy Policies

THIS NOTICE DESCRIBES HOW DIVINE SPEECH AND SWALLOWING SOLUTIONS (HEREINAFTER "DSSS") USES YOUR PROTECTED HEALTH INFORMATION (HEREINAFTER "PHI"), ACCORDING TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HEREINAFTER "HIPAA"), AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

SECTION I – DSSS PLEDGE REGARDING HEALTH INFORMATION:

A. DSSS understands that information about your health care is personal. DSSS is committed to protecting this information. DSSS creates a record of the care you receive. DSSS needs this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by DSSS. This notice will tell you about the ways in which DSSS may use health information about you. DSSS also describes your rights to the health information kept about you, and describes certain obligations DSSS has regarding the use of your health information. DSSS is required by law to:

   1. Make sure that your PHI is kept private.
   2. Give you this notice concerning PHI.
   3. Follow the terms of this notice.

SECTION II – HOW DSSS MAY USE HEALTH INFORMATION ABOUT YOU:

A. The following categories describe different ways that DSSS uses health information. For each category of uses, you will see an explanation and examples. Not every use in a category will be listed. However, all of the ways DSSS is permitted to use health information will fall within one of the categories below.

   1. Treatment, Payment or Health Care Operations - Federal regulations allow health care providers like DSSS, who have a direct treatment relationship with the patient, to use the patient's PHI without the patient's written authorization, and to carry out the health care provider's own treatment, payment or health care operations. DSSS may also share your PHI with another health care provider without your written authorization. For example, if DSSS were to consult with another licensed health care provider about your condition, DSSS would be permitted to disclose your PHI, which is otherwise confidential, in order to assist the health care provider in diagnosis or treatment of your condition.
   2. Treatment Disclosures – Disclosing PHI for treatment purposes is not limited to the minimum necessary standard, because health care providers need access to full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination of health care providers with a third party, consultations between health care providers, and referrals of a patient for health care from one provider to another.

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3. Lawsuits and Disputes – If you are involved in a lawsuit, DSSS may disclose PHI in response to a court or administrative order without a patient's written authorization.

SECTION III – CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

A. As a health care provider, DSSS cannot give a patient documentation of his/her PHI unless DSSS has written permission to do so through the signing of a "Consent to Share PHI" document. This also pertains to the sharing of PHI to any persons outside of those stated in Section IV A-I, not just the patient.

B. As a health care provider, DSSS cannot use your PHI for marketing purposes unless DSSS has written permission to do so through the signing of a "Patient Photography Release" or "Patient Testimony Release" document. Under such circumstances, DSSS can only use the PHI that you have given permission to use according to the signed documentation.

C. As a health care provider, DSSS will not sell your PHI for any reason at any time.

SECTION IV – CERTAIN USES DO NOT REQUIRE YOUR AUTHORIZATION:

A. DSSS health care operations. See Section II A 1.

B. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

C. For health oversight activities, including audits and investigations.

D. For judicial and administrative proceedings, including responding to a court or administrative order.

E. For law enforcement purposes, including reporting crimes occurring on my premises.

F. To coroners or medical examiners, when such individuals are performing duties authorized by law.

G. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

H. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, DSSS may provide your PHI in order to comply with workers' compensation laws.

I. Appointment reminders and health related benefits or services. DSSS may use and disclose your PHI to contact you to remind you that you have an appointment with me. DSSS may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

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SECTION V – CERTAIN USES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

A. Disclosures to family, friends, or others. DSSS may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

SECTION VI – YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

A. You have the right to request limits on the use of your PHI. You have the right to ask DSSS not to use or disclose certain PHI for treatment, payment or health care operations purposes. DSSS is not required to agree with or to fulfill your request, and will provide a written explanation as to why.

B. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

C. You have the right to choose how DSSS shares PHI with you. You have the right to ask DSSS to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and DSSS must agree with all reasonable requests.

D. You have the right to see and acquire copies of your PHI. Other than "session notes," you have the right to get an electronic or paper copy of your PHI in DSSS records. DSSS will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written or verbal request. A signature is required for any request of your own PHI.

E. You have the right to acquire a list of the disclosures DSSS has made regarding your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with written authorization. Your request must be in written form and signed by you. DSSS will respond to your request within 30 days. The list will include disclosures made in the last two years unless you request a different timeframe shorter time. DSSS charges a reasonable service charge to fulfill this request.

F. You have the right to correct or update you PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that DSSS correct the existing information or add the missing information. DSSS is not required to agree with or to fulfill your request, and will provide a written explanation as to why.

G. You have the right to get a paper or electronic copy of this notice.

SECTION VII – EFFECTIVE DATE OF THIS NOTICE:

A. This notice went into effect on January 1, 2022

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SECTION VIII – ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY POLICIES:

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received, read and understand the HIPAA Notice of Privacy Policies. If you are the patient's representative, you understand that by signing this form on behalf of the patient, you are legally binding yourself and the patient to the terms herein.

Print Name of Patient:_____
(Please print name if you are the patient or the legal representative of the patient)

Signature of Patient:_____
(Please sign ONLY if you are the patient)

Date (Month/Day/Year):_____
(Please date if you are the patient or the legal representative of the patient)

Legal Representative Only

Print Name of Legal Representative:_____

Signature of Legal Representative:_____

Relationship to Patient:_____