**Julia M. Hoffman, MA, NLP**

**Transpersonal Healer**

**Spiritual, Intuitive, Energy Healing Practitioner**

**Austin, TX 78704**

**512.318.3382 (cell) www.juliamhoffman.com**

HIPAA Notice of Privacy

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THIS NOTICE DESCRIBES HOW YOUR PRIVATE HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Private Health Information may be used and disclosed in the following circumstances:

1. When required for public health issues such as workman’s compensation.
2. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
3. When required by any state or federal law, including abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservist, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits.

You as the client have rights to your private Health Information, including,

1. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored within 30-60 days.
2. The right to request information of any party that has requested information pertaining to your private health information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing, however, this will not affect any information already disclosed.

I, as a private practitioner have the responsibility to:

1. Make each client aware of the Privacy Notice.
2. At any time make the necessary changes to Privacy Notice that are required by law.

If you as the client feel your privacy has been violated you have the right to complain by filing a written complaint with the Secretary of Health and Human Services in Washington, D.C.

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Julia M. Hoffman, MA to release private health information on my behalf to the following person(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client/Legal Guardian Signature Date

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Client/Legal Guardian Signature Date

**Julia M. Hoffman, MA**

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, & OPERATION**

I understand that as part of my healthcare, Julia M. Hoffman originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment.
* A means for communication among health professionals who contribute to my care.
* A source of information for applying my diagnosis information to my bill.
* A means by which a third-party payer can verify that services billed were provided.
* A tool for routine operations such as assessing quality of care.

I understand and have been provided with a *HIPAA Notice of Privacy* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Julia M. Hoffman reserves the right to change her notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that my health information will not be used for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment or payment. I understand that I may revoke this consent in writing, except to the extent that Julia M. Hoffman has already taken action in reliance thereon.

\_\_\_ I request the following restrictions to the use or disclosure of my health information.

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Client/Legal Guardian Signature Date

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Client/Legal Guardian Signature Date

**Julia M. Hoffman, MA**

# Consent to E-Mail

In order to comply with HIPAA law, I am required to inform you that while my computer is password protected, my E-mail is not considered to be secure.

If you would like to communicate with me via my E-mail, you are required to provide informed consent.

I understand that my E-mail communications with Julia M. Hoffman, MA are not considered secure. However I would like to communicate with her via E-mail.

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Client/Legal Guardian Date

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Client/Legal Guardian Date