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## HIPAA / CONFIDENTIALITY FORM

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This practice is committed to maintaining the strictest privacy and confidentiality standards in the use and handling of any and all medical information we have access to. Any and all patient related information received by this practice is considered confidential. This information is not discussed with anyone unless when necessary to coordinate services and care with other involved therapists, supervisors and management personnel. Any and all therapists, providers or staff member who have access to any type of patient information are oriented to this policy at the time of their hire and as often as necessary afterwards to ensure compliance.

Documentation regarding the clinical records and billing is the property of the agency, and all information recorded is considered confidential. Access to the record either as a hard copy or computer data is limited to those directly providing care, management staff, quality assurance personnel, and representatives of accrediting or regulatory bodies. The release of a written copy of the record is authorized only when the administrator of this practice is satisfied that the request is authorized and approved by the patient or guardian or other legal body having the right of access. Staff/providers must first have the authorization of the administrator before making any copies of the clinical record.

1. Clinical records are kept in a locked and fire-proof file cabinet and may not be removed without permission. All records removed from the file cabinet during the day by authorized personnel must be returned by the end of the same calendar day.
2. Specific copies of documents may be provided to staff providing care, i.e., plan of care, physician orders, intake assessment when it has been deemed necessary. Personnel is responsible for the professional safeguarding of all such copies in their possession and destroying the copies when they are no longer needed.
3. At any time during regular office hours, the patient or authorized agent of the patient being treated may come to the practice and review or request for a copy of their clinical record.
4. In order to allow access to the record, a written release must be valid and signed by the patient or patient's authorized agent.

Any and all staff having access to any patient information are instructed in maintaining the confidentiality of such information during orientation and as often as necessary thereafter to ensure compliance with this policy. This includes but is not limited to the fact that:

1. No patient information may be released to any outside organization, individual or agency without a signed consent which authorizes release as previously stated.
2. They are to immediately inform the administrator of any request for patient information.



## HIPAA / CONFIDENTIALITY FORM (continued)

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3. Great care must be taken to limit the discussion of patients while in public areas.
4. No one should discuss one patient with another patient.
5. They must be responsible to safeguard confidential information in their possession.
6. Staff are cautioned that information shared with any vendors is limited to that required for them to perform the service requested and authorized by the contract.
7. There will be penalties / disciplinary action taken (including dismissal) if a Provider of Capable Therapy violates the HIPAA Privacy Rule.

All Providers of this practice are considered a “covered” entity, that is a person or organization that has access to protected health information and shares that information electronically. As such they are required to follow the HIPAA Privacy Rule.

Each Provider will be given in-service training specifically about what is considered Protected Health Information (PHI), Rules for the Use and Disclosure of PHI, Guidelines to Protect the Privacy of Health Information: How To Protect Patient Privacy, What to do if You think someone’s privacy rights have been violated, and what the consequences are for breaking the rules. Each patient on program is presented with a Notice of Privacy Practices.

I, \_\_\_\_\_, have been issued a copy of Capable Therapy, LLC’s HIPAA/Confidentiality form and informed of HIPAA Compliance standards.

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*