

## NOTICE OF PRIVACY PRACTICES DANIEL WEINER, MA LPC, LLC

The following information explains the privacy practices of Daniel Weiner, MA LPC, LLC (DWLLC). DWLLC consists of Daniel Weiner and the parties contracted by DWLLC. Please do not hesitate to contact me to discuss any questions you may have regarding the following information. You will be asked to sign a consent form acknowledging that you have been informed of the privacy practices.

1. For Treatment: With your written authorization, I may obtain and release information from specific parties that are involved or relevant to your care. I may also release specific information regarding you or an outside individual if there is knowledge of safety/legal issues. In such a particular case, a Release of Information is not required. You will likely be notified if such a disclosure is necessary, unless it is otherwise indicated.
2. For Payment: We may disclose your protected health information (PHI) so that we can bill and receive payment for services provided. This information will likely include diagnosis, treatment plans, and demographic information. The parties informed may include your insurance company, managed care company, and/or guardian/conservator if one is involved. You will be required to sign a Treatment Consent form that further outlines this information. A billing agent contracted by DWLLC will provide this information to the parties identified above and they are required to maintain appropriate privacy guidelines.
3. Phone Contacts: We may call and leave messages regarding appointments, outstanding fees, general issues, etc. We will disclose limited information regarding the nature of the call, if you are not reached directly.
4. Electronic Data: Information regarding your treatment is maintained electronically by DWLLC. This information is safeguarded as DWLLC are the only parties that have access to this information. If information is communicated by email, a written authorization by the client is required. The information is protected by the use of the first name/last initial, and is accompanied by the following statement:

*Confidential Information Attached: This facsimile/email is solely intended for the party above. The records contained in this transmission are strictly confidential and are released pursuant to the Privacy Act of 1974-CT State Statutes Chapter 899 and P.L. 930579. This information may not be released to any other individual or party. **If you have received this fax/email in error, please notify us immediately by telephone/fax/email and destroy all material included in the transmission.***

(cont.)

- You have the right to request restrictions/terminations of the disclosure of your PHI. This can occur at any time during the course of your treatment. We must be notified of such a request in writing. We have the right to uphold the disclosure if safety/legal issues mandate us to report certain information to the appropriate resources. If the restriction/termination of disclosure impedes ethical and appropriate management of care, we may choose to terminate your treatment. If such a termination occurs, we will help provide appropriate referrals with other providers if you would like such assistance.
- You may request reasonable accommodations regarding how you receive communications (ie. messages, emails, etc.). The request should be submitted in writing for accuracy and you will be notified if the request is deemed reasonable.
- You have the right to access/obtain written information from this writer which contains your PHI and that assists in determining decisions regarding treatment. Such a request must be made in writing and is subject to fees predicated by the time required to prepare such material. We may choose to withhold certain types of information in particular situations, in which case we will notify you of the reasons. You have the right to oppose this, or request an independent review by a separate practitioner, at the client's expense.
- Your treatment record will be destroyed between 5-7 years after the termination of your treatment. The records are the sole property of DWLLC and will be maintained in the office of DWLLC. They will be safeguarded by a locked file cabinet/closet and DWLLC is the only party, which has access to such records.
- If you feel that your privacy rights have been violated, you may file a complaint with DWLLC. We will make every effort to address your concerns, however, if you find that the issue is unresolved, you may file a complaint with the Secretary of Health and Human Services.

Daniel Weiner, MA LPC, LLC  
15 North Main Street, 2<sup>nd</sup> Floor  
West Hartford, CT 06107

## **Privacy Practices Consent Form**

I consent to the use or the disclosure of my protected health information (PHI) by Daniel Weiner, MP LPC, LLC (DWLLC) for the purposes of carrying out treatment, and/or obtaining payment. PHI used or disclosed by DWLLC may include, but not restricted to: HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law. (Please note that this information may require you to provide specific authorization.) I understand that information regarding how DWLLC will use and disclose my information is located in the "Notice of Privacy Practices" form which has been given to me. I understand that this consent is effective for as long as DWLLC maintains my PHI.

By signing below, I understand and acknowledge that I have read this consent and have been given the Notice of Privacy Practices.

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Print Name of Individual and/or Personal Representative(parent/guardian)

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Signature of Individual and/or Personal Representative

Date Signed

If signed by the Personal Representative, describe your legal relationship to the client:

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Name of the Client:

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