

**Sarah C. Benoit, LCMHC, LMHC, PLLC**  
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### **Notice of Privacy Information Practices**

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.***

Sarah C. Benoit, LCMHC, LMHC, PLLC is committed to preserving the privacy and confidentiality of your health information that is created and/or maintained in my office. State and federal laws and regulations require me to implement policies and procedures that safeguard the privacy of your health information. This notice will provide you with information regarding my privacy practices and applies to all of your health information created and/or maintained at my office, including any information that I have received from other health care providers or facilities. The notice describes the way in which I may use or disclose your health information and also describes your rights and my obligations concerning such uses or disclosures.

**Treatment:** I may use or disclose your health information to provide you with healthcare treatment and services. I may disclose your health information to doctors, nurses, or other personnel who are involved in your health care. I will obtain your authorization to use and disclose this information except in emergency or life threatening situations. I will share information with other health care providers in order to coordinate your care and services.

**Payment:** I may use or disclose your health information so that I may bill and receive payment from you, an insurance company or another third party for the health care services you receive from me. I may also disclose health information about you to your health plan in order to obtain prior approval for services I provide you, or to determine that your health plan will pay for the treatment. Some insurance require pre-certification.

**Health Care Operations:** I may use or disclose your health information in order to perform the necessary administrative, education, quality assurance and business functions of my office. I may also use your health information to evaluate whether certain treatment or services offered are effective.

**Appointment Reminders:** I may use or disclose your health information for purposes of contacting you to remind you of a health care appointment.

***There are certain situations in which I may be required or permitted by law to use or disclose your health information without your permission. These instances are as follows:***

**Public Health Activities:** I may disclose your health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury, or disability; to report births, deaths, suspected abuse or neglect, reactions to medications, or to facilitate product recalls.

**Health Oversight Activities:** I may disclose your health information to a health oversight agency that is authorized by law to conduct health oversight activities including audits, investigations, inspections or licensure and certification surveys. The activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and ensure compliance with state and federal laws and regulations.

**Worker's Compensation:** I may disclose your health information to worker's compensation programs when your health condition arises out of a work related injury or illness.

**To Avert a Serious Threat to Health or Safety:** I may use or disclose your health information when necessary to prevent a serious threat to the health and/or safety of you or other individuals.

**Inmate:** If you are an inmate of a correctional institution or under the custody of a law official, I may use or disclose your health information to the correctional institution or law enforcement official as may be necessary for 1) the institution to provide you with health care; 2) to protect the health and/or safety of you or another person; or 3) for the safety and/or security of the correctional institution.

## Your Rights Regarding your Health Information

Except for the specific purposes identified above, I will not use or disclose your health information for any other purposes unless I have your specific written authorization. You have the right to revoke a written authorization at any time as long as you do so in writing. If you revoke your authorization, I will no longer be able to use or disclose your health information for the purposes identified in the authorization, except to the extent that I have already taken some action in reliance upon your authorization.

You have the following rights regarding your health information. You may exercise each of these rights, in writing, by providing me with a completed form that I am able to provide. In some cases, I may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding cost is available upon request.

**Right to Inspect and Copy:** You have the right to inspect and request a copy of health information that may be used to make decisions about your care. I may deny your request to inspect and copy your health information in certain limited circumstance. If you are denied access to your health information, you may request that the denial be reviewed.

**Right to Amend:** You have the right to request an amendment of your health information that is maintained by or for my clinic and is used to make health care decisions about you. I may deny your request if it is not properly submitted or does not include a reason to support your request. I may also deny your request if the information sought to be amended: 1) was not created by me; 2) is not part of the information that is kept by or for my office; 3) is not part of the information you are permitted to inspect and copy; or 4) is accurate and complete.

**Right of an Accounting Disclosure:** You have the right to request an accounting of the disclosure of your health information made by me. This information will not include disclosures of health information that I made for purposes of treatment, payment or healthcare operations pursuant to a written authorization that you have signed.

**Right to Request Restriction:** You have the right to request a restriction or limitation on the health information I use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information I disclose about you to someone, such as a family member or friend who is involved in your care or the payment of your care. I am not required to agree to your request. If I do agree, that agreement must be in writing and signed by both of us.

**Right to Request Confidential Communication:** You have the right to request that I communicate with you about your health care in a certain way or certain location. For example, you may ask that I only contact you at work or by mail.

**Right to a Paper Copy of this Notice:** You have the right to receive a paper copy of this notice. You may ask to be given a copy of this notice at any time.

If you have any questions regarding this notice or wish to receive additional information about my private practice, you may do so. If you believe your rights have been violated, you may file a complaint with the Secretary of the DHHS. You will not be penalized for filing a complaint.

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I, \_\_\_\_\_ have received from Sarah C. Benoit, MS, LCMHC, LMHC, a written Notice of Privacy Information Practices as required by federal HIPPA regulations.

\_\_\_\_\_  
Signature of client or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

