



HIPAA WAIVER

Early Start Autism, LLC is committed to protecting the patient and family's health information.

THIS NOTICE DESCRIBES HOW PATIENT INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN THIS INFORMATION. PLEASE REVIEW CAREFULLY.

A federal regulation, known as the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), requires that we provide detailed notice in writing of our privacy practices.

Early Start Autism, LLC is committed to protecting patient health information.

1. HIPAA requires that we protect health information which identifies a patient or family, information which is called Protected Health Information, also known as PHI.
2. We will maintain the privacy of all PHI.
3. We give you this notice of our legal duties and privacy practices.
4. We reserve the right to change this notice in accordance with current law and provide you with a copy of the revised notice.

How we may use and disclose Protected Health Information without your written authorization or opportunity to agree or object.

1. For Treatment: We may use and disclose PHI to provide, coordinate, and manage your/your family member's health care and related services. Examples include disclosure of PHI when you/your family member requires referral to a physician, health care professional, hospital, or other specialized testing or therapy.
2. For Payment: We may use and disclose PHI in order to verify your/your family member's coverage for a particular treatment and services and to collect payment for your/your family member's treatment and other services from third party payers including your health plan, their paid reviewers, and other insurance companies providing you/your family member with additional coverage.
3. For Health Care Operations: We may use and disclose PHI in order to help improve the quality of your/your family member's care and reduce its cost. This includes providing training to other health care providers or institutions, providing information to professionals who help up improve and maintain the quality and efficiency of the services that we provide to you/your family member and to others, resolving grievances which occur within our practice, and converting PHI to de-identified health information, data which cannot be associated with you/your family member or with other members of your family.
4. For Communication from Our Office to You: We may use and disclose PHI to remind you of appointments and to provide you with information about alternative therapies.
5. For Compliance with law: We may use and disclose PHI to comply with applicable federal, state, or local laws including worker's compensation and Medicare laws.
6. For Compliance with Public Health Directives: We may use and disclose PHI to assist public health and other authorities in their efforts to prevent or control communicable diseases, general or school-based injuries, disabilities, and injuries or complications from FDA-regulated medications or devices.



7. For Prevention and Control of Abuse, Neglect, or Domestic Violence: We may use and disclose PHI to properly constitute government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.
8. For Health Oversight Activities: We may use and disclose PHI to a health oversight agency for audits, investigations, inspections, licensure and disciplinary activities, and other activities necessary to monitor the health care system including government health care programs.
9. For Support of Legal Proceedings: We may use and disclose PHI when ordered by a court order, subpoena, or discovery requests.
10. For Support of Law Enforcement: We may use and disclose PHI to law enforcement authorities if the patient is a suspected crime victim, if law enforcement authorities indicate that it is necessary to locate a suspect, fugitive, material witness, or a missing person, if it relates to a crime or suspected crime committed in this office, if it is in response to a medical emergency not occurring in the office, and if it is necessary to report a crime and its nature, location, and the identity of those who committed the crime.
11. For Selected Research Activities Allowed or Required by the HIPAA Privacy Act: We may use and disclose PHI to government agencies for certain research or oversight of our practice and others and to you/your family member should you/your family member desire it.
12. For Prevention of a Serious Threat to Health or Safety: We may use and disclose PHI to an appropriate person about you/your family member in limited circumstances to prevent a threat to the health or safety of you/your family member, another person, or to the public.
13. For Support of Certain Specialized Government Activities: We may use and disclose PHI to support certain activities including military maneuvers, executive protection, national security, intelligence gathering, and protection of the health of persons in custody.

ALL OTHER USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION REQUIRE YOUR WRITTEN AUTHORIZATION. AT ANY TIME, YOU MAY REVOKE YOUR AUTHORIZATION, BUT ACTIONS TAKEN PRIOR TO YOUR REVOCATION WILL STAND

Your rights regarding Protected Health Information about you/your family member:

1. Right to Request Restrictions: You have the right to request restrictions on the PHI that we may use for treatment, payment, and health care operations. To request restrictions, you must make your request in writing to Melissa Burkhardt. We are not required to comply with your request if we feel that it is in violation of the above-noted legal directives. In such a case, we will provide you with a written notice of denial.
2. Right to Receive Confidential Communications: You have the right to request that you receive communication containing PHI in a certain manner or at a certain location. You must make your request in writing to the owner, Melissa Burkhardt, specifying how and where you would like to be contacted. We are required to accommodate reasonable requests.
3. Right to Inspect and Copy: You have the right to inspect or copy PHI about you. This does not include PHI gathered for a civil, criminal, or administrative proceeding. We may deny your request only in limited circumstances. You must make your requests to inspect and copy in writing to Melissa Burkhardt. We may charge you a reasonable fee for copying, postage, labor, and supplies used to meet your request.



4. Right to Amend: You have the right to amend the PHI about you/your family member as long as such information is kept by or for our office. This request must be made in writing to Melissa Burkhardt, and you must include a reason for the request.
5. Right to receive an accounting of disclosures: You have the right to request an accounting of certain disclosures of your/your family member's PHI. This request, in writing to Melissa Burkhardt must be for a list of disclosures other than those specified in Section I, and made during a time period of up to six years.

Complaints

If you believe that your/your family member's privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact our Patient Rights' Officer, Melissa Burkhardt. We will not retaliate or take action against you/your family member for filing a complaint.

Melissa Burkhardt 11718 SE Federal Hwy #245 Hobe Sound, FL 33455

I have read, understand, and agree with the policy of HIPAA outlined in the documentation provided.

Print Child/Client Name _____

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____



Media Release Form

In some circumstances, it is beneficial to have photographs or make video recordings of children during therapy for programmatic purposes. Such situations include video modeling to teach children new skills, videos to help train new staff on the child's team or parents and photos to use in picture schedules and other visual supports. In addition, such videos can be beneficial to other clients and families for the purposes of training and marketing.

As an ESDM autism scholarship Recipient, Parent/Legal Guardian MUST agree to the use of videotapes and audio tapes to record parent coaching sessions. Permission to video record or take photographs of your child for the additional purposes listed below is always at the client's discretion. This permission can be revoked by the client at any time by providing a written update to Early Start Autism, LLC.

_____ **ALLOW: By my initials here and my signature below, I hereby give my permission to ALLOW my child to be photographed or video recorded (containing no personal identifying information) for the following additional purposes:**

Programming: This may include videos for the purposes of teaching your child new skills or providing necessary prompts to teach your child new skills. Examples include video modeling to teach your child new skills, use of photographs for visual schedules or visual supports for your child.

Training of my child's staff: This may include videos of your child working with other staff to training new staff for your child's team or other caregivers of your child (e.g., parents, teachers, grandparents, etc.). This may also include videos of you and your child participating in parent coaching for further certification/training of the ESDM therapist.

Classroom Training, Workshops and Webinars: Therapists, new staff, and other families or caregivers occasionally participate in workshops or in-services. It is helpful to have visual aids, such as videos or pictures, demonstrating therapy and behavior strategies. Videos or photographs of the child would be used in such a way with all reasonable efforts taking to not reveal the child's identity.

Promotional Materials: These videos and/or photographs are taken of children/clients participating in therapy to illustrate on our website, flyers, and other marketing materials what we do in therapy. No identities are on the children/clients or the specifics of their diagnosis or needs.

_____ **NOT ALLOW: If use of videotapes, audio tapes, or photographs of my child for publicity or media purposes is NOT ALLOWED, at least one Parent/Legal Guardian must initial here on this separate line item and must also sign below. Videotapes and audio tapes will still be used to record parent coaching sessions but will not be used for publicity or media purposes.**

Print Child/Client Name _____

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____