Deborah Serani, Psy.D.
Psychologist | Psychoanalyst
12 Ivy Hill Drive, Smithtown, New York 11787
631.366.4674 | deborahserani@gmail.com

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT FORM

Name: ______________________________

Address: ______________________________ **Date of Birth** __________

- ☐ I understand that my protected health information (PHI) is safeguarded under HIPAA, the Health Insurance Portability and Accountability Act.
- ☐ I understand that psychotherapy requires confidentiality and privacy for treatment success, and that **DEBORAH SERANI, PSY.D.** will protect my privacy and preserve confidentiality of my PHI.
- ☐ I understand that **DEBORAH SERANI, PSY.D.** may use my PHI to handle billing and insurance issues, communicate with collaborative care professionals that I sign releases for, as well as other health related operations that may occur in psychotherapy.
- ☐ I understand that the laws that protect the confidentiality of my PHI also apply to telemedicine sessions that may occur with **DEBORAH SERANI, PSY.D.**
- ☐ I understand that protected health information may be released without my consent or authorization under the following conditions:
  - Suspected or known child abuse or neglect
  - Suspected or known sexual abuse of a child
  - Adult and Domestic abuse
  - Judicial or administrative proceedings (i.e. you are ordered here by the court)
  - Serious threat to health or safety (i.e. “Duty to Warn” and Threat to National Security)
- ☐ I understand that I have the right to request permissions and restrictions of certain uses and disclosures of my PHI and will do so in writing with **DEBORAH SERANI, PSY.D.**
- ☐ I understand that I have the right to inspect, amend and copy my PHI, and if I have questions, can discuss them with **DEBORAH SERANI, PSY.D.**
- ☐ I understand that if **DEBORAH SERANI, PSY.D.** has breached HIPAA regarding my PHI, I can file a grievance at the New York State Office of Mental Health at 1-800-597-8481 or the Office of Civil Rights, Regional Office, Department of Health and Human Services at 1-800-368-1019.
- ☐ I understand if I cancel this consent **DEBORAH SERANI, PSY.D.** is not obligated to provide further mental health care services to me.

Name: ______________________________

Patient Signature: ______________________________ **Date:** __________

Authorized Signature (if minor): ______________________________ **Date:** __________