Pialee Roy, Ph.D.
Health Coach/Life Coach/Personal Consultant
Owner of Sparkly Life Health Coaching Inc.
NOTICE OF PRIVACY PRACTICES, page 1 of 2

THIS NOTICE DESCRIBES HOW (MEDICAL/MENTAL) HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY: I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all (medical/mental) health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Pialee Roy, Ph.D., and of your individual rights and Pialee Roy's legal duties with respect to confidential information.

Ways in which I may use and disclose your protected Health information:

I may use and disclose at my discretion your medical records for each of the following purposes only: care provided by health coaching/life coaching/professional consultation, payment and health care operations.

● **Care** means providing, coordinating or managing health coaching, life coaching, and/or professional consultation and related services.

● **Payment** means activities such as obtaining payment for the professional services I provide for you, health coaching/life coaching/professional consultation, from your insurance or another third party payer.

● **Health care operations** include the business aspects of running a professional services.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care. I will use and disclose your protected health information when required by federal, state or local law. There are certain situations in which as a health coach/life coach/personal consultant, I am required by ethical standards to reveal information obtained during sessions to persons or agencies even if you do not give permission.

These reportable situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing. I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand my use of your information for care, payment and health care operations as stated above.

Your printed name: _____
Your signature:

_____

Date: _____