
Notice of Privacy Practices

Pediatric Neuropsychology Associates PLLC

Effective Date: 12/1/2025

Review Frequency: Periodic review as needed or when regulatory or operational changes occur

Record Retention: Documentation is retained in accordance with applicable federal and Florida law. HIPAA-related documentation is maintained for a minimum of six (6) years. Clinical records are retained for at least seven (7) years following the last date of service. For minor patients, records are maintained until the patient reaches the age of majority and for an additional seven (7) years thereafter, unless a longer retention period is required by law, professional standards, or risk-management guidance.

Purpose of This Notice

This notice describes how medical information about the patient may be used and disclosed, and how you can access that information.

Scope of This Notice

Applies to PHI created, received, maintained, or transmitted through clinical services and operations. Does not apply to the public website, which is governed separately by the Website Privacy Policy. The website is not intended for transmission of PHI. If information submitted through the public website becomes part of the clinical record, it will be treated as PHI and governed by this Notice.

What is PHI?

PHI includes identifiable information relating to health status, healthcare services, or payment. This includes information related to the patient's:

- Physical or mental health
- Healthcare services received
- Payment for those services

Quick Summary of Your Rights

As a parent/legal representative, you have the right to:

- Access or request a copy of the patient's medical records.
- Ask us to correct health information you believe is wrong.
- Ask for limits on how we use or share the patient's information.
- Request private communication methods.
- Be notified in case of a breach involving the patient's PHI.
- File a complaint without fear of retaliation.

Who is a Parent/Legal Representative?

For purposes of this notice, a parent/legal representative is an individual authorized under applicable state law to make healthcare decisions on behalf of a minor patient.

Our Legal Duty

We are required by law to:

- Maintain the confidentiality of the patient's health information under the Health Insurance Portability and Accountability Act (HIPAA), Florida state law, and other applicable laws.
- Provide you with this notice of our legal duties and privacy practices.
- Notify you in the event of a breach that compromises the privacy of the patient's PHI.
- Follow the practices described in this notice.
- We apply the minimum necessary standard.
- We notify individuals of breaches within 60 days of discovery.

We maintain administrative, technical, and physical safeguards to protect the patient's protected health information from unauthorized access or disclosure.

How We May Use and Disclose PHI Without Authorization

The law allows us to use or disclose the patient's PHI without written authorization (consent) in certain cases, including:

1. Treatment

To provide, coordinate, or manage the patient's healthcare and related services. For example, consulting with the patient's pediatrician regarding assessments or recommendations.

2. Payment

To obtain payment for services (e.g., collecting payment, providing invoices/superbills at your request, and responding to payer requests if you seek out-of-network reimbursement).

3. Healthcare Operations

For quality improvement, staff training, licensing, accreditation, credentialing, internal audits, business planning, legal compliance, and other activities necessary to operate and support our practice.

Other Uses and Disclosures Permitted Without Authorization

We may also use or disclose the patient's PHI without your authorization in the following legally required or permitted situations:

- When required by law, such as reporting child abuse or neglect.
- For public health or health oversight purposes, including audits and investigations.
- In response to legal requests like court orders or subpoenas with appropriate safeguards.
- To avert or lessen a serious threat to health or safety.
- For workers' compensation claims, as permitted by law.
- As required under Florida law regarding minors and mental health, particularly regarding confidentiality and consent.

When using or disclosing protected health information, we make reasonable efforts to limit the information to the minimum necessary to accomplish the intended purpose, except for disclosures for treatment or as otherwise required by law.

Uses and Disclosures That Require Authorization

We will obtain your written permission before using or disclosing the patient's PHI for:

- Use or disclosure of psychotherapy notes, except as permitted by law.
- Marketing communications, which means using PHI to promote products or services.
- Sale of protected health information, which means transferring PHI for financial compensation.
- Disclosures to third parties for non-treatment purposes.
- Disclosures to schools or educational institutions without a valid written authorization, unless permitted by law for treatment coordination or safety purposes.
- Any other uses or disclosures not specifically permitted by law or this notice.

You may revoke your authorization at any time in writing. However, your revocation will not affect any action already taken in reliance on your previous authorization.

Your Rights Regarding the Patient's Health Information

As a parent/legal representative, you have the following rights concerning the patient's health information:

1. Right to Access

You may inspect or receive a copy of the patient's health records, with limited exceptions. We may charge a reasonable, cost-based fee for copies, mailing, or electronic delivery. We will respond within 30 days.

2. Right to Amend

If you believe information is incorrect or incomplete, you may request an amendment in writing. We may deny the request under certain conditions but will notify you in writing. We will respond within 60 days.

3. Right to an Accounting of Disclosures

You may request a list of disclosures of the patient's PHI made in the prior six years, excluding disclosures for treatment, payment, or healthcare operations. The first request in a 12-month period is free; reasonable fees may apply for additional requests.

4. Right to Request Restrictions

You may ask us not to use or disclose certain health information for treatment, payment, or healthcare operations. We are not required to agree but will consider your request. If you pay out-of-pocket in full for a service, you may request that we not disclose that information to a health plan, unless required by law.

5. Right to Request Confidential Communications

You may ask us to communicate with you in a specific way or at a different location. We will accommodate reasonable requests. While we take reasonable precautions to protect electronic communications, such methods may carry inherent privacy risks.

6. Right to a Paper Copy of This Notice

You may request a paper copy at any time, even if you agreed to receive it electronically.

7. No Waiver of Rights

Exercising any of your rights under this notice will not affect the patient's access to care.

8. Florida-Specific Privacy Protections

Florida law provides enhanced privacy protections for mental health and neuropsychological records.

Mental Health Records

Florida Statutes require strict confidentiality of psychological and neuropsychological records. Disclosure generally requires the patient's or legal representative's written consent, except where disclosure is permitted or required by law, including mandatory reporting obligations. Certain sensitive information may also be exempt from release under specific circumstances.

Minor Consent Laws

Under Florida law, minors may, in limited circumstances, legally consent to certain outpatient mental health services independently. When a minor consents to treatment independently:

- Their records cannot be disclosed to a parent or guardian without the minor's written consent, unless disclosure is required by law or necessary to prevent serious harm.
- Your access to the patient's mental health records may be limited in these circumstances.

We follow all applicable federal and Florida laws regarding the privacy of psychological and neuropsychological records. For neuropsychological evaluation services involving minors, parents or legal guardians are typically involved in consent and receipt of evaluation information unless otherwise required by law. This Notice of Privacy Practices serves as the primary and complete description of our privacy practices for this practice.

Complaints

If you believe the patient's privacy rights have been violated, you may contact:

Our Practice:

Pediatric Neuropsychology Associates PLLC
954-284-0048
2699 Stirling Rd Suite C306C
Ft. Lauderdale FL 33312
admin@pediatricneuropsychologyassociates.com

Privacy Officer Contact

For privacy-related questions or concerns, please contact our Privacy Officer at the number or email listed above.

Office for Civil Rights (OCR):

U.S. Department of Health and Human Services
www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you for filing a complaint.

Contact Information

For questions about this notice or need further information, please contact us:

Pediatric Neuropsychology Associates PLLC
954-284-0048
2699 Stirling Rd Suite C306C
Ft. Lauderdale FL 33312
admin@pediatricneuropsychologyassociates.com

Changes to This Notice

We reserve the right to change the terms of this Notice of Privacy Practices and the privacy practices we maintain. Any changes will be posted in our office, and you may request a revised copy at any time. Changes apply to all PHI we maintain, regardless of when it was created.

Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

Parent or Legal Representative Consent and Acknowledgment (for Minors or Individuals Lacking Legal Capacity)

I acknowledge that I have received, read, and understood the Notice of Privacy Practices of Pediatric Neuropsychology Associates PLLC, which describes how protected health information may be used and disclosed and explains my rights regarding that information. I understand that this document is provided for informational purposes and does not require my consent for services. I have had the opportunity to ask questions about this Notice, and I understand that I may request a copy at any time.

By signing below, I confirm that I am the parent or legal representative of the patient named below, that I am legally authorized to receive and acknowledge this information on the patient's behalf, and that the information I have provided regarding my legal authority is accurate.

I understand that I am not required to sign this acknowledgment. If I choose not to sign, the practice will document that the document was provided to me.

Printed Name of Patient:

Printed Name of Parent/Legal Representative:

Signature of Parent/Legal Representative:

Relationship to Patient:

Date:

A copy of this signed form will be retained in the patient's health records.

For Office Use Only

Date Received:

Received By:

Staff Role:

Filing Method: Paper File Digital File Both

Notes: