



## Notice of Privacy Practices

*Effective date: January 1, 2026*

**THIS NOTICE DESCRIBES HOW MEDICAL AND PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### **Our Pledge Regarding Your Health Information**

We understand that your psychological and health information is private. We are committed to protecting your Protected Health Information (PHI). This Notice describes how we may use and disclose your PHI to carry out treatment and health care operations, and describes your rights regarding your PHI.

### **How We May Use and Disclose Your PHI**

**For Treatment.** We may use and disclose PHI to provide, coordinate, or manage your mental health care and related services. Example: sharing treatment notes with a consulting clinician at your request.

**Other permitted/disclosed uses without your consent or authorization.** Examples include when required by law, for public health activities, law enforcement purposes in limited circumstances, to avert a serious threat to health or safety, or as required by a court order.

### **Cash/Check/Credit Card-Only Practice**

This practice does not participate in any health insurance plans and does not submit claims on your behalf. All services are provided on a self-pay basis. Because of this, disclosures of your PHI for purposes of insurance payment do not apply here.

### **Psychotherapy Notes**

Psychotherapy notes are treated specially under HIPAA. We will not disclose psychotherapy notes without your signed authorization except in the few circumstances permitted by law.

### **Your Rights Regarding PHI**

You have the following rights. To exercise these rights, submit a written request to the Privacy Officer (contact info below).

1. Right to Inspect and Copy.
2. Right to Amend.
3. Right to an Accounting of Disclosures.
4. Right to Request Restrictions (including no disclosure to insurers, since this is a cash-only practice).
5. Right to Request Confidential Communications.
6. Right to a Paper Copy of This Notice.

### **Breach Notification**

If there is a breach of unsecured PHI, we will follow federal breach notification requirements and notify you, and when required, we will notify HHS and other authorities as required.



## Complaints

If you believe your privacy rights have been violated, you may file a complaint with us using the contact information below, or with the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services. Filing a complaint will not affect your treatment.

### OCR complaint contact options:

Online OCR Complaint Portal

Email: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov)

Mail: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201

Phone / TDD: 1-800-368-1019 / TDD 1-800-537-7697

**Connecticut state reporting:** To report a breach or notify the Connecticut Attorney General, use the AG's online data breach submission form or send updates to [ag.breach@ct.gov](mailto:ag.breach@ct.gov)

## Changes to This Notice

We reserve the right to change our privacy practices and this Notice. If we change the Notice, the new Notice will be effective for all PHI we maintain. We will post the current Notice at the practice and on our website (if applicable).

## How to Contact Us / Privacy Officer

**Privacy Officer:** Joslyn Cruz, Ph.D.

**Mailing address:** 68 South Main Street, Suite 200, West Hartford, CT 06107

**Email:** [JoslynCruzPhD@gmail.com](mailto:JoslynCruzPhD@gmail.com)

**Phone:** 860-325-2349



## Acknowledgment of Receipt

### *of Notice of Privacy Practices*

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for the practice of Joslyn Cruz, Ph.D. I have had the opportunity to review the Notice and to ask questions about how my Protected Health Information (PHI) may be used and disclosed.

### Client / Patient Information

Client Name (printed): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Service / Today's Date: \_\_\_\_\_

### Signatures

Client Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

*If signing on behalf of a minor or incapacitated client:*

Parent / Guardian / Personal Representative Name (printed): \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

### For Office Use Only

If the client refused or was unable to sign this acknowledgment, the provider documents the good-faith effort to obtain written acknowledgment and the reason it was not obtained.

Reason acknowledgment not obtained: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_