NYS Lic. No. 014457-1
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HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health condition and related health services.

Uses and Disclosures of PHI: Your PHI may be used and disclosed by your physician, my office, and others outside my office that are involved in your care and treatment for the purpose of providing health care services to you, to pay our health care bills, to support the operation of the practice, and ant other use required by law.

Treatment: I will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of tour health care with a third party, for example, I would disclose your PHI, as necessary, to a home health agency that provides care for you. Your PHI may be provided to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose you.

Payment: Your PHI will be used, as needed, to obtain payment for your mental health care services. For example, obtaining approval for continued sessions may require that your relevant PHI be disclosed to the health plan to obtain approval for the sessions.

Healthcare Operations: I may use or disclose, as needed, your PHI in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, licensing and conducting or arranging for other business activities. For example, I may call you by name in the waiting room when I am ready to see you. I may use PHI, as necessary, to contact you and remind you of your appointment.

I may use or disclose your PHI in the following situation without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases; Abuse and Neglect (DYFS, Adult Protected Services); Food and Drug Administration requirements; Legal Proceedings; Criminal Activity; Workers Compensation.

Other Permitted and Required Uses and Disclosures will be made ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT unless required by law

You may revoke this authorization/notice, at any time, except to the extent that your physician/organization has taken an action in reliance on the use or disclosure in the authorization.

You have the right to inspect your PHI: Under federal law, however, you may not have or inspect the following records: psychotherapy/psychiatric notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI: This means you may ask me not to use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practice. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician/organization is not required to agree to a restriction that you may request. If your physician/organization believes it is in your best interest to permit use and disclosure of your PHI, it will not be restricted.

You then have the right to use another healthcare professional. You have the right to obtain a paper copy of this notice from me. You have the right to receive an accounting of certain disclosures, if any, I have made of your PHI. I reserve the right to change this notice and will inform you of any changes. you then have the right to change this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to me or the Secretary of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Ave., S.W., Room 509F, HHH Building, Washington DC, 20201, if you believe your privacy right has been violated by me. I WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

I am required by law to maintain the privacy of and provide individuals with this notice of my legal duties and privacy practices with respect to PHI. Signature below is only to acknowledge that you have received this Notice of Privacy Practices.

Print Name:_____ Signature: _____ Date: _____