**Notice of Patient Privacy Rights and Consent**

This notice describes how medical information about you may be used and disclosed and how you can access this information. This Practice may use or disclose your protected health information to the extent that it is required by law. We also may use and disclose your health information without your consent or authorization as allowed or required by federal and/or California law. We have the right to refuse to treat you should you choose not to disclose your Personal Health Information (PHI). If you choose to give consent in this document, you may revoke your consent in part or in full at any time in the future. However, you may not revoke consent for actions that have already been taken which relied on this signed consent form or a previously signed consent. Please review this document carefully before signing. We are happy to answer any questions that you may have.

**YOUR RIGHTS**

* The right to receive a copy for our “Notice of Privacy Practices”, which details how your health information may be used or disclosed by the organization.
* The right to review or obtain a copy of the medical records of your minor children if you are the legal guardian. The Practice has the right to charge reasonable fees for copying health information that you request be provided to you. Any request for records or health information will be responded to within the legal timeframe of fifteen (15) days of the request. Should the processing of your request be delayed, the Practice will inform you at the soonest opportunity.
* The right to request restrictions on the use of or disclosure of your medical records.
* The right to receive your health information at an alternate address or through alternate delivery means, such as by fax, email, or courier. The Practice has the right to charge reasonable fees for copying health information that you request be provided to you. Any request for records or health information will be responded to within the legal timeframe of fifteen (15) days of the request. Should the processing of your request be delayed, the Practice will inform you at the soonest opportunity.
* The right to request amendments or changes to your medical records, with certain limitations. such as if you believe the records are inaccurate or incomplete. Requests must be made in writing. The Practice will respond to your request within sixty (60) days of your request informing you of the actions taken or notice of the denial of your request. Your rights and our obligations are more fully listed in 45 CFR § 164.526
* The right to obtain a list of those with whom we’ve shared your information.
* The right to file a privacy complaint directly with us or with the federal government.
* The right to designate someone to act for you. You may revoke such designations at any time.
* The right to designate someone to act in your stead should you become ill or incapacitated.

**YOUR CHOICES**

**You have some choices in the way that we use and share information as we:**

* Tell family and friends about your condition, if you are present, and provide your consent.
* Marketing our services and the selling of your information.
* Use and disclosure of psychotherapy notes.
* Tell family and friends about your condition, if you are not present, in exercise of your professional judgment.

**OUR USES AND DISCLOSURES**

**Listed below are uses and disclosures that are permitted or required by law.**

* Provide appropriate treatment for you and share it with other health professionals as necessary.
* Aid in emergency situations in which we need to render your care.
* Assistance in disaster relief efforts, for purposes of coordinating your care with state or local relief services.
* Run our organization as per scheduling, treatment, and communication with you.
* Share with Business Associates (BAs) that undertake some essential administrating functions in the operation of this office.
* Respond to research study’s applicable legal requirements if the practice is involved in such activities.
* Bill for your services and share your health information with health plans, if necessary.
* Responding to organ and tissue donation requests.
* Help with the public health and safety issues for disease prevention or other injuries and help with recalls.
* Respond to specialized Government Functions when authorized by law with regards to certain law enforcement, military, and veteran activities.
* Prevent abuse, neglect, or domestic violence when authorized by law to prove information if we believe someone is at risk including reporting to Social Services or Protective Service Agencies.

**OUR RESPONSIBILITES**

* Comply with the HIPAA Law in the sharing of health information with State and Federal Agencies.
* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it, if requested.
* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**The privacy rule was also created to provide a standard for certain health case providers to obtain their patients’ consent for uses and disclosures of health information and for marketing purposes.**

**ATTESTATION AND CONSENT**

Yes or No (Initial) \_\_\_\_\_\_\_\_ I consent for the office to leave messages on my answering machine or my cell phone.

 Phone number to be used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes or No (Initial) \_\_\_\_\_\_\_\_ I consent for this office to send me emails concerning my medical treatment.

Email address to be used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes or No (Initial) \_\_\_\_ I consent for the office to send me emails concerning marketing purposes.

 Email address to be used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned certifies that he/she has read the foregoing Notice of Privacy Practices and is the patient, or the patient’s personal representative. Copy is available upon request.

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Name of Patient Signature of Patient

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Name of Patient’s Personal Representative Signature of Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed

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Name of Employee Signature of Employee

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHANGES TO THE TERMS OF THIS NOTICE**

**We reserve the right to revise or amend this Privacy Policy at any time. These revisions may be effective for all Protected Health Information (PHI) we maintain, even if created prior to the effective date of the revision. The new notice will be available on request, in our office, and on our website.**