**MANHATTAN DERMATOLOGY, PLLC**

**71 PARK AVENUE SUITE 1A 36A EAST 36TH STREET**

**NEW YORK, NY 10016 NEW YORK, NY 10016**

**WILLIAM LONG, M.D. GEORGE G. KIHICZAK, M.D.**

**WENDY LONG MITCHELL, M.D. TAYLOR DEFELICE, M.D.**

**FORREST N. WHITE, M.D. VICKI J. LEVINE, MD**

**PHONE (212) 689-9587 FAX (212) 689-8519 PHONE (212) 683- 6073 FAX (212) 689-8519**

**NAME OF PATIENT** (LAST) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_ (FIRST) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (M.I.)\_\_\_\_\_\_

**SOCIAL SECURITY NUMBER** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_ **DATE OF BIRTH** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE** \_\_\_\_\_\_

**SEX**  M / F **MARITAL STATUS** S / M / D / W / DP

**ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CITY**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ZIP CODE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREFERRED PHONE #** \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ **CELL/HOME #** \_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ **WORK #**\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_­

**EMAIL** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHARMACY PHONE #** \_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

**NAME OF EMPLOYER** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OCCUPATION** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHONE #** \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

**DO YOU HAVE A PRIMARY CARE PHYSICIAN? Y /N**

**IF SO, PLEASE PROVIDE THE FOLLOWING:**

**PRIMARY CARE PHYSICIAN NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHONE #** \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

**IF YOU WERE REFERRED BY A PHYSICIAN, PLEASE PROVIDE THE FOLLOWING:**

**NAME OF REFERRING PHYSICIAN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHONE #** \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

**IF NOT REFERRED BY A PHYSICIAN, HOW DID YOU HEAR ABOUT OUR OFFICE?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:**

ACNE HEART DISEASE LYME DISEASE ROSACEA

ASTHMA HIGH BLOOD PRESSURE MRSA SEASONAL ALLERGIES

HIGH CHOLESTEROL HEART ARRHYTHMIA PACEMAKER STOMACH ULCER/GERD

BLEEDING PROBLEMS HEPATITIS A B C PSORIASIS THYROID DISEASE

CHICKEN POX/SHINGLES HERPES ONYCHOMYCOSIS TINEA VERSICOLOR

DEPRESSION HIV PARKINSON’S DISEASE URTICARIA (HIVES)

DIABETES I OR II HPV RHEUMATOID ARTHRITIS/ LUPUS VITILIGO

ECZEMA KIDNEY/LIVER DISEASE

OTHER MEDICAL PROBLEMS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ CANCER, PLEASE SPECIFY

**ARE YOU PREGNANT, NURSING, OR TRYING TO CONCEIVE?** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you currently smoke?** Y/ N If yes, how many stick/pack\_\_\_\_\_\_ per day **Are you a former smoker?** Y / N

**Do you drink alcohol?** Y / N If yes, how much per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL HISTORY OF SKIN CANCER** **FAMILY HISTORY OF SKIN CANCER OR SKIN DISEASE**

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

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**LIST ALL ALLERGIES** **LIST ALL MEDICATIONS, SUPPLEMENTS, VITAMINS**

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

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

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**REASON FOR TODAY’S VISIT**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WILL YOU FURNISH A PHONE NUMBER WHERE WE MAY LEAVE A MESSAGE WITH CONFIDENTIAL MEDICAL INFORMATION, SUCH AS LAB RESULTS? YES / NO**

**IF YES, PLEASE PROVIDE NUMBER \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_**

**MAY WE TEXT APPOINTMENT REMINDERS TO YOUR CELL PHONE NUMBER? Yes \_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_**

**CANCELLATION POLICIES**

IF YOU MUST CANCEL OR RESCHEDULE YOUR APPOINTMENT, YOU MUST DO SO AT LEAST **ONE BUSINESS DAY** PRIOR TO YOUR APPOINTMENT. IF YOU MISS AN APPOINTMENT WITHOUT DOING SO, WE WILL PUT THROUGH A **$50.00** CHARGE ON YOUR CREDIT CARD. \*\*\* **PLEASE INITIAL HERE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\*\***

FOR SURGICAL PROCEDURES, ½ HOUR COSMETIC APPOINTMENTS, MOHS MICROGRAPHIC SURGERY APPOINTMENTS, SCITON AND FRAXEL LASER APPOINTMENTS OR PATCH TESTING APPOINTMENTS, YOU MUST CANCEL AT LEAST **ONE BUSINESS DAY** PRIOR TO YOUR APPOINTMENT OR YOU WILL BE CHARGED A **$250** FEE.

 \*\*\* **PLEASE INITIAL HERE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\*\***

**FINANCIAL POLICIES**

ALL COPAYS ARE EXPECTED AT THE TIME OF THE VISIT.

YOU MAY RECEIVE A SEPARATE BILL FOR LAB CHARGES.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR INSURANCE PLAN’S POLICIES AND TO GET REFERRALS FROM YOUR PRIMARY CARE PHYSICIAN IF REQUIRED BY THE PATIENT’S INSURANCE PLAN. EVEN IF WE ARE IN NETWORK WITH YOUR INSURANCE, DEDUCTIBLES OR COINSURANCE MAY APPLY FOR MEDICALLY REQUIRED SERVICES, WHICH MEANS YOU MAY BE RESPONSIBLE FOR A PORTION OF THE CHARGES. \*\*\* **PLEASE INITIAL HERE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\*\***

THIS FORM AND MY SIGNATURE AFFIXED HERETO MAY SERVE AS A SIGNATURE-ON-FILE TO BE USED TO AUTHORIZE DISCLOSURE OF THE MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME, AND TO FILE ALL FUTURE INSURANCE CLAIMS RELATED TO MY CARE.

I ALSO AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO DR. WILLIAM T. LONG, DR. WENDY S. LONG MITCHELL, DR. FORREST N. WHITE, DR. GEORGE G. KIHICZAK, DR. VICKI J. LEVINE, AND/OR DR. TAYLOR M. DEFELICE THE AMOUNT DUE TO ME IN PENDING CLAIMS FOR MEDICAL OR SURGICAL TREATMENT OR SERVICES RENDERED TO ME.

I ACKNOWLEDGE I HAVE RECEIVED/HAVE ACCESS TO A COPY OF THIS PRACTICE’S NOTICE OF PRIVACY PRACTICES.

PATIENT’S OR RESPONSIBLE PARTY’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S OR RESPONSIBLE PARTY’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_

MANHATTAN DERMATOLOGY, PLLC

71 PARK AVENUE SUITE 1A 36A EAST 36TH STREET

NEW YORK, NY 10016 NEW YORK, NY 10016

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PHONE (212) 689-9587 FAX (212) 689-8519 PHONE (212) 683- 6073 FAX (212) 689-8519

Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your health care needs.

Insurance companies and employers do not cover deductibles, coinsurances and copayments, as you know. It is our office policy to collect patients’ credit card information to allow payment for these items and so avoid the need to bill you later. This saves expense for the billing and time for you and the office.

By signing below, you authorize payment by credit card in the amounts listed as patient responsibility by your health benefit plan for services (including, but not limited to, co-insurance, deductibles and/or uncovered services). We do not store your sensitive credit card information in our office. We store it in a secure site called a gateway. We access your information on this site only to process a payment.

We appreciate your cooperation in this matter and will guard your financial information under government HIPAA and HITECH guidelines.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INFORMATION EXCHANGE,**

**CARE EVERYWHERE AND HEALTHIX**

**CONSENT FORM**

Practices Please Fax signed consents to: **917-829-2096**

**William T. Long, M.D.**

**Manhattan Dermatology, PLLC** Patient **MRN**/Patient ID in EMR:

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange (“NYULMC HIE”) website http://health-connect.med.nyu.edu/ (“HIE Participants”) and non-NYU health care providers who may request access to your medical records for purposes of current treatment (“Care Everywhere Providers”) to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749**.** Upon request, your provider will print this list for you from the Healthix website.

**YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.**

The NYULMC HIE and Healthix share information about people’s health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, “Better Information Means Better Care.” You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

**PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.**

**Your Consent Choices**. You can fill out this form now or in the future. You have the following choices:

Please check Box 1 or 2:

**1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

**2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency*.

**NOTE: UNLESS YOU CHECK THE “I DENY CONSENT” BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_**\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT Name of Patient Patient Date of Birth

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

Signature of Patient or Patient’s Legal Representative Date

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

Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Patient (if applicable)

**HIPAA Omnibus Notice of Privacy Practices**

**Revised 2013**

Effective as of April/14/2003

**Manhattan Dermatology**

**71 Park Avenue, Ste. 1A 36A E. 36th Street, Ste. 202**

**New York, NY 10016**

**212-689-9587 212-683-6073**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

# Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

* You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
* We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

* You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
* We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications**

* You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
* We will say “yes” to all reasonable requests.

**Ask us to limit what we use or share**

* You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
* If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

**Get a list of those with whom we’ve shared information**

* You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
* We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
* We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

* You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [**www.hhs.gov/ocr/privacy/hipaa/complaints/**](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.**
* **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

# Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

* Share information with your family, close friends, or others involved in your care
* Share information in a disaster relief situation
* Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

* Marketing purposes
* Sale of your information
* Most sharing of psychotherapy notes

In the case of fundraising:

* We may contact you for fundraising efforts, but you can tell us not to contact you again.

# Our Uses and Disclosures

## How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

## **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

* Preventing disease
* Helping with product recalls
* Reporting adverse reactions to medications
* Reporting suspected abuse, neglect, or domestic violence
* Preventing or reducing a serious threat to anyone’s health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you:

* For workers’ compensation claims
* For law enforcement purposes or with a law enforcement official
* With health oversight agencies for activities authorized by law
* For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

# Our Responsibilities

* 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
* 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.
* We will never share any substance abuse treatment records without your written permission.

# **Changes to the Terms of this Notice**

# We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

# Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

**Acknowledgment of Receipt of the Notice of Privacy Practices**

**Name of patient or representative**