**HIPAA NOTICE**

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NOTICE OF PRIVACY PRACTICES

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

WHO WILL FOLLOW THIS NOTICE:

This notice describes information followed by me or by any staff I may employ in the future. The “designated privacy officer” is Deborah Kim, MD, my primary psychiatrist.

YOUR HEALTH INFORMATION:

This notice applies to the information and records I have about your health, health status, and the healthcare and services you receive at our offices. The office is permitted by federal privacy laws to make uses and disclosures of your

health information for purposes of treatment, payments, and health care operations. Protected health information is the information I create and obtain in providing healthcare services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing

documents for those services.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

Signing this form allows the disclosure of your health information under circumstances outlined below. I must have your written and signed consent to use to disclose health information for the following purposes:

1. For Treatment. I use health information about you to provide medical treatment or services. I may share information about you and disclose information to people who do not work in my office in order to coordinate your care, such as phoning/faxing prescriptions to your pharmacy and scheduling/ordering lab work. Prior authorization for medications as required by your insurance company will require disclosure of your protected health information. Family members and other healthcare providers outside this office may be part of you medical care and may require information about you that I have.

2. For Payment. I may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment collected from you, an insurance company, or a third party. For example, I may need to give your health plan information about services you receive here so that they will reimburse you for services provided. I may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

3. For Healthcare Operations. If I hire additional staff, I may use and disclose health information about you to run the office and make sure you receive quality care, for example, to help with scheduling or billing. I obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. I will share information about you with such insurers or other business associates as necessary to obtain these services.

4. Appointment Reminders. I may contact you as a reminder that you have an appointment at the office.

5. Treatment Alternatives. I may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

6. Health-Related Products and Services. I may tell you about health-related products or services that may be of interest to you.

**Please notify me if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise me that you do not wish to receive such communications, I will not use or disclose your information for these purposes.**

You may revoke your Consent at any time by giving me written notice. Your revocation will be effective when I receive it, but it will not apply to any uses and disclosures that occurred before that time. If you revoke your Consent, I will not be permitted to use or disclose information for purposes of treatment, payment, or healthcare operation, and I may therefore choose to discontinue providing you with healthcare treatment.

SPECIAL SITUATIONS:

I may use or disclose health information about you WITHOUT your permission for the following purposes, subject to all applicable legal requirement and limitations:

1. Prevention of a Serious Threat to Health or Safety. I may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the general public.

2. Required by Law. I will disclose health information about you when required to do so by federal, state, or local law. I may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

3. Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, I may be required by military command or other government authorities to release health information about you. I may also release information about foreign military personnel to the appropriate foreign military authority.

4. Worker’s Compensation and Employer. I may release health information about you for workers’ compensation or similar programs, but I would request your consent first. I may release health information about you to your employer if I provide health care services to you at the request of your employer, and the health care services are provided either to conduct

an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, I will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only with specific authorization from you for the release of that information to your employer.

5. Public Health Risks. I may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products. I must report any unreported and suspected child abuse which is occurring or has occurred at any time in the state of Pennsylvania. I will follow state law in reporting and in some cases, may be reporting to multiple authorities in multiple states.

6. Health Oversight Activities. I may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

7. Lawsuits and Disputes. If you are involved in a lawsuit or dispute, I may disclose healthcare information about you in response to a court or administrative order. Subject to all applicable legal requirements, I may also disclose health information about you in response to a subpoena.

\* Please note for forensic clients, all information will be shared with your attorney as per our contract.

8. Law Enforcement. I may also release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.

9. Coroners, Medical Examiners and Funeral Directors. I may release health information to a coroner or medical examiner, for example, if necessary to identify a deceased person or determine the cause of death.

10. Information Note Personally Identifiable. I may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

11. Family and Friends. I may disclose health information about you to your family member or friends if I obtain your written or verbal agreement to do so. I may also disclose health information to your family or friends if I can infer from the circumstances, based on my professional judgment, that you would not object, for example if you bring them into the office with you during treatment or when treatment is discussed. Please notify me of any specific issues that you do not want discussed in front of another person in such a situation. In situations where you are not capable of giving consent (because you are not present or due to you incapacity or medical emergency), I may, using my professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only health information relevant to that person’s involvement in your care. I may also use my judgment to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, prescriptions or medical records.

12. Disaster Relief. I may use and disclose your protected health information to assist in disaster relief efforts.

13. Food and Drug Administration (FDA). I may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, medications, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

14. You have the right to designate a person to make health care decisions for you, should you lose the ability to make decisions for yourself (ex. – if you are unconscious, suffer severe memory impairment, etc.) Please indicate whether there is a particular person that you wish to make decisions for you, should you lack decision making capacity. If you are younger than 18 years old, I require permission to speak with your parents at my discretion. I require an emergency contact even if that person is not eligible to make decisions for you in case there is an emergency in the office.

**Name of person to make decisions for you or emergency contact**

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**You may contact this person if I do not show up to appointments**

**\_\_\_ YES \_\_\_\_ NO**

**This person can be contacted to make decisions for me**

**\_\_\_ YES \_\_\_\_ NO**

**Contact information for person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

I will not use or disclose your health information for any purpose other than identified in the previous sections without your specific, written Authorization. I must obtain this Authorization separate from any Consent I may have obtained from you. If you give me Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, I will no longer use or disclose information about you for reasons covered by that written Authorization, but I cannot take back any uses or disclosures already made with you permission. If I have medical information about you regarding HIV or substance abuse, I cannot release that information without a special signed, written Authorization (different from the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment, or healthcare operations, I will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

Our Responsibilities

The office is required to maintain the privacy of your health information as required by law.

You have the following rights regarding health information I maintain about you:

1. Right to Inspect and Copy. You have the right to inspect and copy your health Information, such as medical and billings records, that I use to make decisions about your care. You must submit a written request to me in order to inspect and/ or copy your health information. If you request a copy, I may charge a fee for the costs of copying, mailing, or other associated supplies. I may deny the request to inspect or copy in certain limited circumstances such as psychotherapy notes. If you are denied access to your health information, you may ask that the denial be reviewed by a licensed psychiatrist. If such a review is required by law, I will comply with the outcome of the review.

2. Right to Amend. If you believe health information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment as long as I keep the information. To request an amendment, you must submit a request in writing. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that I did not create (unless the person/entity who created the information is no longer available to make the amendment), that is not part of the health information I keep, that you would not be permitted to inspect and copy, or that is accurate and complete.

3. Right to an Accounting of Disclosures. You may request a list of the disclosures I made of medical information about you for purposes other than treatment, payment, and healthcare operations. To obtain this list, please submit your request to me in writing. It must state a time period which may not be longer than six years and may not start before August 1, 2012. Your request should state that you want the list in writing. I would notify you of the charge for the costs of providing the list so you may choose to withdraw or modify your request before any costs are incurred.

4. Right to Request Restrictions. You may request a restriction or limit on the health information I use or disclose about you for treatment, payment, or healthcare operations. You also may request a specific limit on the health information I disclose about you to someone who is involved in you care or the payment for it. I am not required to agree to your request, for example, if I think it will cause danger or harm to that person, but if I do agree, I will comply with you request unless the information is needed to provide you with emergency treatment. To request restrictions, please submit a written request to me.

5. Right to Request Confidential Communications. You may request that I communicate with you about medical matters in a certain way or at a certain location, for example, only at a certain phone number. To request confidential communications, please submit a written request to me. I will accommodate all reasonable requests, but your request must specify how or where you wish to be contacted.

6. Right to a Paper Copy of this Notice. You may ask me for a copy of this notice at any time. To obtain one, please contact me.

CHANGES TO THIS NOTICE:

I reserve the right to change this notice, and to make the revised or changed notice effective for medical information I already have about you as well as any information I receive in the future. You may request a copy of the current notice by contacting me.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with me, with your insurance plan, or with the Secretary of the Department of Health and Human Services. To file a complaint with me, please contact me. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of July 1, 2018. If you are under 18 years old your parent must sign this form.

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Signature of Patient/Patient Representative. Date

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Relationship to patient