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Child and Adolescent Psychiatry
ADHD and behavioral disorders Clinic

Notice of Policies and Practices to Protect the Privacy of Your Health Information.

This notice describes how Psychiatric and Medical Information About you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment and Heal Care Operations

I may *use* or *disclose* you *protected health information* (PHI), for treatment, payment and health care operations purposes ***with*** your consent. To help clarify these terms, here are some definitions:

- ***PHI*** refers to information in your health record that could identify you.
- ***Treatment, Payment and Health Care Operations***
- ***Treatment*** is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician.
- ***Payment*** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
- ***Health Care Operations*** are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
- ***Use*** applies only to activities *within my office* such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- ***Disclosure*** applies to activities *outside my office,* such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. An *authorization* is written permission above and beyond the general consent that permits only specific disclosures, such as the release of psychotherapy notes. ***In those instances when I am asked for information for purposes outside of treatment, payment, and health care operation, I will obtain an authorization from you before releasing this information.***

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing.
You may not revoke an authorization to the extent that (1)I have relied on that authorization: or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, may be, abused, neglected or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the State Board of Medical Examiners, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made of me for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party, or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health and Safety:** If I determine that there is a probability of imminent physical injury by your child to self or others, or there is a probability of immediate mental or emotional injury, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

IV. Patient's Rights and Psychiatrist Duties

Patient's Rights:

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction that you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that are seeing me. Upon your request, I will send your bills to another address.)
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. In most cases I am permitted by law to charge

a fee to cover the administrative costs associated with this request. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- **Right to Amend** – You hae the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent not authorization (as described in section III of this notice). On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy**- You have a right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychiatrist Duties

- I am required by law to maintain the privacy of the PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by terms currently in effect.
- If I revise my policies and procedure, I will make the revised notice available for review in my office. The revised notice may also be sent to you by U.S. mail, or a copy may be given to you during

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at my office: 2201 E. Iowa Rd, Ste B EdingburgM, TX 78539; Telephone (956) 803-2111; Fax 956-289-7194.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, 1301 Young St, Suite 1169, Dallas, Texas 75202; Telephone (214) 767-4056; Fax (214) 767-0432

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on August 1, 2019.
I reserve the right to change the terms of this notice and to make the new provisions effective for all PHI that I maintain. I will provide you with a revised notice by U.S. mail, or at the time of a scheduled appointment in my office.

In order to comply with the Health Information Portability and Accessibility Act (HIPAA), effective August 1, 2019, your signature is required on this form. It will be kept in your patient record to indicate that you have read and/or received a copy of our notice of policies and practices to protect the privacy of your health information.

I certify that I have received and reviewed a copy of the Notice of Policies and Practices.

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Patient name **Parent/guardian name** **Parent/Guardian Signature** **Date**