# 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 IT CAREFULLY

## Use and Disclosure

I typically use or share your health information for the following purposes:

1) Treatment: I can use your health information and share it with other professionals who are treating you.
   *Example: If I consult with your primary care physician about your overall health condition.*
2) Payment: I can use and share your health information to bill and get payment from health plans or other entities.
   *Example: Using your payment data on file to charge payment for services received.*
3) Healthcare operations: I can use and share your health information to run my practice, improve your care, and contact you when necessary.
   *Example: Using your data for quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.*

There are some reasons for which I would be permitted to disclose your protected health information with your oral agreement, including:

1) Sharing information with a family member of yours who is involved with your treatment what they need to know

There are some reasons for which I would be required to disclose your protected health information without your agreement, including:

1) The mandated report of abuse or neglect (see informed consent for further information),
2) In accordance with judicial and administrative proceedings (for example, in response to a court order),
3) And in compliance with law enforcement purposes.

Uses and disclosures that require your written authorization include:

1) Disclosure or sharing of psychotherapy notes unless for treatment, training, in response to related legal action brought by the patient, or certain other regulatory and law enforcement exceptions.
2) For marketing purposes
3) Sale of protected health information

## Your Rights

You have the right to:

1) Ask me to limit the information I use or share for treatment, payment, and healthcare operations. I am not required to agree to a requested restriction unless the disclosure is for payment or healthcare operation purposes and the request is solely regarding an item or service you or another individual (other than your health plan) has paid for in full.
2) Receive confidential communication of your protected health information (for example, requesting that I only call certain phone numbers or send information only to certain addresses). I will accommodate all reasonable requests.

3) See and/or receive a copy of your protected health information. To do this, you will need to make a request in writing, to which I will respond in writing typically within 30 days. I may charge a reasonable, cost-based fee.
4) Correct your protected health information if you believe any of the information is incorrect or incomplete. To do this, you will need to make a request in writing, including the reason for the request, to which I will respond in writing within 60 days.
5) Request a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why. I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I'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.
6) Receive a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.

**My Duties**

1) I am required by law to maintain the privacy of protected health information, to provide you with notice of my legal duties and practices regarding protected health information, and to notify affected individuals following a breach of unsecured protected health information.
2) I am required to abide by the terms of the version of this notice currently in effect.
3) I reserve the right to make changes to this notice that apply to the protected health information I maintain, however, if I do so, I will provide you with a revised notice either electronically or in hard copy, according to your preference, and it will be available upon request.

**Complaints**

If you believe I have violated your privacy rights as outlined in this notice, you may bring your concerns to me directly; however, 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/

I will not retaliate against you for filing a complaint.

Please feel free to contact me for further information if you desire:
Carl Waitz, PsyD
617-453-8238
cw@carlwaitzpsyd.com

Effective date: 6/11/2020

By signing here, you acknowledge that you have received this notice no later than the date of first service delivery, unless in an emergency.

_____ _____

Patient/Guardian signature Date