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THE MILLMAN CLINIC

HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you may have access to this information. Please read it carefully and then sign the Acknowledgment.

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 that privacy or security. We must follow the duties and privacy practices described in this Notice and give you a copy of it. Please note that we may change the terms of this Notice and that changes will apply to all information we have about you. Any updated Notice will be provided to you upon request.

A Summary of Your Rights, Your Choices, Our Uses and Disclosures:

Your Rights.

You have the right to:

- Receive a copy of your paper or electronic medical record.
- Correct your paper or electronic medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we've shared your information.
- Receive a copy of this Notice of HIPAA Privacy Practices.
- Have your legal representative make choices for you.
- File a complaint if you believe your privacy rights have been violated.

Your Choices.

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

- Tell family and friends about your medical condition.
- Provide disaster relief.
- Provide mental health care.
- Market our services.

Our Uses and Disclosures.

We may use and share your information as we:

- Treat your medical condition.
- Run our organization.
- Bill for your services.

- Help with public health and safety issues.
- Do research.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions as needed.

Section 1. 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 understand them. You have the right to:

1. **Receive an electronic or paper copy of your medical record.**
    - You can ask to see or receive an electronic or paper copy of your medical record and other health information we have about you. You may 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 for providing a copy to you.
2. **Ask us to correct your medical record.**
    - You can ask us to correct health information about you that you think is incorrect or incomplete. You may ask us how to do this.
    - We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. **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.
4. **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. 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 purposes of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
5. **Receive a list of those with whom we've shared information.**
    - You may ask for a list of the times we've shared your health information for 6 years prior to the date you make the request, 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 list a year for free but we will charge a reasonable, cost-based fee if you ask for another one within 12 months of the first request.

6. **Receive a copy of this HIPAA Notice of Privacy Practices.**

   - You may 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.

7. **Have your legal representative make choices 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 legally make decisions for you before we take any action.

8. **Revoke consent to sharing.**

   - You have the right to revoke consent to us sharing your personal health information at any time so long as you do it in writing. Please note that this doesn't apply to any information that has been shared in the past. It only applies going forward.
   - It also doesn't apply to any situations where we are required by law or in the public interest of health or safety of others or any other exceptions we have described in this Notice.

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

   - You can complain if you feel we have violated your rights by contacting us.
   - You can file a complaint by sending a letter to U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **hhs.gov/ocr/privacy/hipaa/complaints/**.
   - We will not retaliate against you for filing a complaint.

Section 2. 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 to tell us what you want us to do, and we will follow your instructions.

1. **Share with family, friends, and others.**
   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.

2. **Share in a disaster relief situation.**
   You have the right and choice to tell us to share information in a disaster relief situation. However, if you are not able to tell us your preference (for example, if you are unconscious), we may share your information if we believe it is in your best interest.

We NEVER share your information in these situations, unless you give us written permission:

1. **Most occasions around sharing any psychotherapy or mental health notes.**

    - You would need to give us additional permission to share your mental health information with others in most situations.

2. **Marketing or sale of your personal information.**

    - We will not use your personal health information in our marketing.
    - We will not sell your personal health information to others.
    - We will not use or share your information other than as described in this Notice unless you tell us that 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.

Section 3. 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, including ways that contribute to the public good, such as public health and research, provided we meet certain conditions under the law.

1. **Treat your health condition.**

    - We can use your health information and share it with other medical professionals who are treating your health condition.
      Example: A doctor treating you for an injury asks another doctor about your overall health condition.

2. **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.

3. **Bill for your services.**

    - We can use and share your health information to bill and receive payment from health plans, insurance companies, or other entities.
      Example: We give information about you to your health insurance plan so it will pay for your services.

4. **Help with public health and safety issues.**

    - We may share personal health information about you in certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, and reporting suspected abuse, neglect, or domestic violence.

- We may also share your information when needed to lessen a serious and imminent threat to anyone's health or safety.

5. **Do research.**

   - We can use or share your information for health research purposes.

6. **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 the government wants to see that we're complying with federal privacy laws or other laws.

7. **Respond to organ and tissue donation requests.**

   - We may share personal health information about you with organ procurement organizations.

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

   - We may share personal health information with a coroner, medical examiner, or funeral director.

9. **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.

10. **Respond to lawsuits and legal actions.**

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

This Notice of Privacy Practices is effective as of this date: _____. Should you have questions about this Notice of Privacy Practices, there is someone in our office who we have identified as our Privacy Officer who handles privacy issues. You may contact our office at:

Privacy Officer's Name: Dr Kim Millman
E-mail address: drkim@themillmanclinic.com
Phone Number: 408.218.9301

For Patient Signature:

HIPAA Acknowledgement Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other health care providers involved in my treatment).

2. Obtaining payment from third party payers (for example, insurance companies).

3. The day-to-day health care operations of your practice.

I have also been informed of and given the right to review and obtain a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that you reserve the right to change the terms of this Notice from time to time and that I may contact you at any time to obtain the most current copy of this Notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____
Patient Signature _____
Date _____

If Patient is unable to sign, then a Representative may sign on the Patient's behalf:
Representative Name _____
Representative Signature _____
Date _____
Relationship to Patient _____