Bartholomew Thomas Vereb, M.D., M.A.

Child & Adolescent Psychiatry
General Psychiatry

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Bradenton, Florida 34209-3835 www.PsychiatryBradenton.com

NOTICE OF PRIVACY PRACTICES

Privacy Officer: Bartholomew Thomas Vereb, MD
Notice Effective Date: 06/01/2011

*****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.*****

We understand your medical information is private and we strive to protect the confidentiality of your medical records. The new federal regulations require that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. The practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to the protected health information.

This notice will be followed by any health care professional authorized to enter information in your medical records. All employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be used.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment:

We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you are allergic to specific drugs that could influence with medications we prescribe for the treatment purpose.

For Payment:

We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from your insurance, third party or you. Example: We may need to send your protected health information, such as your name, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment.

Health Care Operations:

We may use and disclose medical information about you for health care operations to assure that you receive quality care.

Example: we may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

· As required during an investigation by Law enforcement agencies
· To avert a serious threat to public health and safety
· As required by military command authorities for their medical records
· To workers' compensation or similar programs for processing of claims, if claim initiated by patient.
· In response to certainlegal proceeding
· To a coroner or medical examiner for identification of body
· In an inmate, to the correctional institution or law enforcement official
· In rare and unusual circumstances, as required by a US Food and Drug Administration (FDA) officer.
· Other healthcare providers' treatment activities
· Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
· Uses and disclosures required by law
· Uses and disclosures in domestic violence or neglect situations
· Health Oversight activities
· Other public health activities

We may contact you to provide appointment reminders, information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and disclosures of Protected Health Information Requiring Your Written Authorization:

Other uses and disclosures of medical information not covered by this Notice or the Laws that apply to us will be made only with your written authorization. If you give us a written authorization to use or disclose the medical information about you, you may revoke the authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHT REGARDING YOUR MEDICAL INFORMATION

Complaints:

If you believe your privacy rights have been violated, you may file the complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not bepenalized or discriminated against for filing the complaint.

Right to Request Restriction:

You have the right to request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations or to someone who is involved with or in your care or the payment for your care. We are not legally bound to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with the emergency treatment. To request restrictions you must submit your request in writing. In your request, you must tell us what information you want limited.

Right to Request Confidential Communication:

You have the right to request how we should send our communications to you about medical matters, and where you would like these communications sent. We will not ask you for the reason for your request. Your request must specify how or where you wish to be contacted. We reserve the right to deny the request, or charge an appropriate fee, if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy:

You have a right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in civil, criminal or administrative action or proceeding and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about your care, you must submit your decision in writing. If you request a copy of the information, we reserve the right to charge the fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to

your medical information, you may request that denial be reviewed.

Right to a Paper Copy of This Request:

You have a right to a paper copy of this Notice at any time. Even if you agreed to receive this copy electronically, you are still entitled to a paper copy.

Right To Amend:

If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be submitted in writing. In addition you must provide a reason that supports your request. We 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, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement and any corresponding rebuttals will be kept on file and sent out with any future request for information pertaining to the appropriate portion of your records.

Changes to This Notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, with the effective date at the very beginning of the notice.

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PATIENT ACKNOWLEDGEMENT

I understand that, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain right to privacy in regards to my protected health information (PHI).

I have received, read and understood The Notice of Privacy Practices.

The practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practice on request.

I, the patient, or the legal guardian/parent of the patient, acknowledge that a paper copy of the document was offered to me today.

I have elected to:

1) Take a printed copy of this document with me today ☐

2) I refuse the printed document at this time.

I will access, read, download, or print this document from the web site of this practice ☐

Patient Name:_____ DOB: _____

Patient Signature_____

Patient's Parent/Guardian Signature:_____

Printed Name _____

Relationship to the Patient _____

****

I was unable to obtain the patient's signature: Name_____ Sign here_____

Date_____

Reason_____ (May use back of page.)