Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identity you and that relates to your past, present, or future physical or mental health or condition related health care services is referred to as Protected Health Information (PHI). This notice of privacy practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms oft his Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new notice of Privacy Practice will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by handing you a new copy at your next appointment or via mail or email per your request.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for providing, coordinating or managing your health care treatment and related services. This includes consultation with other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: determining eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to used collection processes due to lack of payment of services, we only disclose the minimum amount of PHI necessary.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPPA without authorization:

Abuse and neglect, Judicial and administrative proceedings, deceased persons, emergencies, family involvement in care, health oversight, law enforcement, national security, public health.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclose that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government audits or investigations.
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission:

We may use or disclose your information to family members that are directly involved in your treatment with verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to:
Erica Leon, MS, RD, CDN
75 S. Broadway
White Plains, NY 10601

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment or payment. We are not required to agree with your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to: Erica Leon, MS, RD, CDN, at 9 Springwood Avenue, Ardsley, NY, 10502, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 of by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is January 1, 2010.

NAME: _____

DOB: _____

I hereby acknowledge that I have been given an opportunity to read a copy of this Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the undersigned.

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Signature of Patient **Date:**

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Signature of Parent or Guardian **Date:**

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Clinician Signature **Date:**