THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.

1. PURPOSE: Dr. Bhat and his professional staff, employees and trainees follow the privacy practices describes in this Notice. The office keeps your health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment all professional staff involved in your treatment and employees involved in the health care operations of the agency may have access to your records.

2. WHAT ARE TREATMENT AND HEALTH CARE OPERATIONS? Your treatment includes sharing information among health care providers who are involved in your treatment. For example, if you are seeing both a physician and specialist they may share information in the process of coordinating your care. Treatment records may be reviewed as part of an on-going process directed toward assuring the quality of Agency operations.

3. HOW WILL THE OFFICE USE MY PROTECTED HEALTH INFORMATION? The record that is maintained by clinicians at the office and will be designated as your protected mental health record may include the following: information pertaining to medication prescription and monitoring; the modalities and frequencies of treatment furnished; results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Your personal health record will be retained by the office for approximately ten years after your last clinical contact with the office. After that time has elapsed, the record will be shredded or burned or otherwise destroyed in a way that protects your privacy. Until the records are destroyed information revealed by you will be kept confidential except under the following conditions:

A. We reserve the right to seek supervision and consultation from professional colleagues within our agency, which will aid us in our work with you. These colleagues, also, will treat your information as confidential. Information discussed in consultation may include protected mental health information.

B. If we believe you pose a life-threatening risk to yourself or others, we may need to notify responsible individuals for your protection or the protection of others.

C. Cases of suspected abuse or neglect of children or adults not otherwise able to protect themselves may be reported in compliance with state law.

D. If records are court ordered to be released.

E. If otherwise required by state or federal law.

Due to the highly confidential nature of our services, client records are handled with great sensitivity. All staff members are trained in understanding and respecting client confidentiality. Staff handle records only when necessary. Client files are securely stored. Some client data is maintained electronically (i.e. data base) and appointment schedules are kept electronically. In all cases, measures are taken to protect the security and confidentiality of those records.

The office compiles statistical data (e.g. demographic information, presenting concerns) to measure effective treatment and improve services. The statistical data is made public record. Names or other information that would identify specific clients is never a part of that statistical data.

4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES. Except as described previously, we will not use or disclose information from your record unless you authorize (permit) in writing the office to do so. You may revoke your permission, which will be effective only after the date of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION. You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form provided by the office.

- Right to request restriction. You may request limitations on your health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

- Right to confidential communications. You may request communications in a certain way or at a certain location.

- Right to inspect and copy. You have the right to inspect and copy your health information regarding decisions about your care. We may charge a fee for copying, mailing and supplies.

- Right to request clarification of record. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. You may ask for a form for that purpose and the form will require certain specific information. The office is not required to accept the information that you propose.

- Right to accounting of disclosures. You may request a list of any non-authorized disclosures of your mental health information that have been made to persons or entities other than for treatment or health care operations in the last six (6) years, but not prior to April 14, 2003.

- Right to copy this notice. You may request a copy of this notice at any time, even if you have been provided with a copy previously.

6. REQUIREMENTS REGARDING THIS NOTICE: The office is required to provide you with this Notice that governs our privacy practices. The office may change its policies or procedures in regards to privacy practices. If and when changes occur, the changes will be effective for health information we have about you as well as any information we receive in the future. Any time you come into the office for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

7. COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the office, or with the Office. You will not be penalized or retaliated against in any way for making a complaint.

I acknowledge that I have received the “notice of privacy act” from Sanjay T. Bhat, MD PC.

Patient Name: ________________________________ Date of Birth:_____________

Patient Address:_____________________________________

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Patient Signature:_____________________________ Date:___________________