NOTICE OF PRIVACY PRACTICES

CLEARINSIGHT
PSYCHIATRY, INC.

PLEASE REVIEW THIS NOTICE CAREFULLY BEFORE SIGNING

ClearInsight Psychiatry, Inc is required to inform of our privacy practices and follow the terms within this notice as they remain in effect. We are required by law to maintain the privacy of your protected health information (PHI) and provide you with notice of our legal obligations with respect to your protected health information. This information consists of all records related to your health, including demographic information, either created by ClearInsight Psychiatry, Inc or received from other healthcare providers. Our primary responsibility is to safeguard your personal health information. We will notify you in the event we become aware of unauthorized access, use, or disclosure of your unsecured protected health information.

Uses and Disclosures Requiring Authorization:

ClearInsight Psychiatry, Inc may use or disclose your protected health information for purposes outside of treatment, payment, and health care operations when the appropriate authorization is obtained. In those instances ClearInsight Psychiatry must inform you prior to releasing your information. We may not disclose protected health information to any family member, friend, or other entity who may be involved in your care without your verbal or written consent.

Situations Requiring Your Verbal Consent:

These instances include changes in personal information and demographics, such as your name, gender, home address, and insurance information.

Situations Requiring Your Written Consent:

For any other instances not covered in the sections above, we will obtain your written consent. This permission is described as an "authorization." If you authorize us to use or disclose your health information, you may revoke that authorization in writing at any time. Upon revocation, disclosure of your health information will be prohibited for reasons stated in your written authorization. Please understand we are unable to rescind any disclosures that have already been made with your consent, and are required to retain a record of the care we provide to you.

Situations Not Requiring Your Consent:

Protected health information may be released without written permission to the legal custodian of a child or incompetent adult, a public conservator, the healthcare agent designated power of attorney for incapacitated patients, and the representative or spouse of a deceased patient. Additionally, ClearInsight Psychiatry may use or disclose your protected health information without your written authorization for certain treatment, billing, and healthcare purposes. These include, but are not limited to:

- ➢ Providing, coordinating, or managing your healthcare and related services between one or more healthcare providers, which may involve referrals to other health agencies for treatment
- ➢ Activities undertaken by ClearInsight Psychiatry, Inc to obtain reimbursement for services provided to you, as outlined in your financial obligations
- ➢ Instances required by military command authorities, if you are currently serving as a member of the armed forces
- ➢ When required to do so by federal, state or local law

Emergency situations where ClearInsight Psychiatry, Inc is permitted to disclose your protected health information without your authorization, or call upon proper authority to ensure your safety and the safety of others, include, but are not limited to:

- ➢ Circumstantial evidence of self-harm, and intent to harm others
- ➢ When required by law for purposes which include reporting abuse, neglect, domestic violence, or injuries believed to have occurred as a result of a crime
- ➢ Public health and safety procedures which require us to report infectious diseases to health authorities

It is our practice to use your registration information to send you appointment reminders. We may also contact you in regards to treatment alternatives and services that may be of interest to you. You must notify us if you do not wish to receive appointment reminders or information in regards to certain treatment alternatives and services.

Right to Examine Your Medical Records:
You have the right to examine your own health record within 5 business days of our receipt of your written request. You have the right to obtain a copy of your own health record within 15 days of our receipt of your written request and payment. You also have the right to request corrections in your medical record.

Note: This notice is prepared in accordance with the Health Insurance Portability and Accountability Act (HIPAA) 45 CFR 164.520. Medical Doctors are licensed and regulated by the Medical Board of California. (800) 633-2322, www.mbc.ca.gov.

Upon signing below, I acknowledge receipt of the Notice of Privacy Practices given to me.

Patient Signature:_____ **Date:**_____

Printed Name:_____