

Journey Well Now

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NOTICE OF PRIVACY PRACTICES

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

Updated: September 23, 2013

We respect patient/client confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by this Practice.

Privacy Contact: If you have any questions about this policy or your rights contact Dr. Ronni Greenberg at 773-405-6007.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when I may need to share your confidential information with others beyond my office. This includes for:

Treatment:

With your written consent, I may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside my office that I am consulting with or referring you to.

Payment:

With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations:

I may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

I will also obtain an authorization from you before using or disclosing:

- Protected Health Information in a way that is not described in this Notice.
- Psychotherapy notes

INFORMATION DISCLOSED WITHOUT YOUR CONSENT

Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies:

Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care:

At times we may be contacting you to regarding your future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you or billing questions. We will leave appointment information on your answering machine or voice mail unless you tell us not to.

As Required by Law:

This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners:

We are required to disclose information about the circumstance of your death to a coroner who is investigating it.

Governmental Requirements:

I may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. I am also required to share information, if requested, with the U.S. Department of Health and Human Services to determine our compliance with federal laws related to health care and to Illinois state agencies or insurance companies that fund your care.

Criminal Activity or Danger to Others:

If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. I also have the right to involve law enforcement when I believe an immediate danger may occur to someone.

·When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

PATIENT RIGHTS

You have the following rights under Illinois and federal law:

Copy of Record:

You are entitled to inspect record. We may charge you a reasonable fee for copying and mailing your record.

Release of Records:

You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record:

You may ask us not to use or disclose part of the clinical information. This request must be in writing. I am not required to agree to your request if I believe it is in your best interest to permit use and disclosure of the information. The request should be given to the **Privacy Contact**.

Contacting You:

You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. We also will be glad to provide you information by email if you request it. If you wish us to communicate by email you are also entitled to a paper copy of this privacy notice.

Amending Record:

If you believe that something in your record is incorrect or incomplete, you may request we amend it. In certain cases, we may deny your request. On your request, your psychologist will discuss with you the details of the amendment process.

Accounting for Disclosures:

You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period, no longer than six years and after April 14, 2003, please submit your request in writing to our **Privacy Contact**. We will notify you of the cost involved in preparing this list.

Questions and Complaints:

If you have any questions, or wish a copy of this Policy or have any complaints you may contact our **Privacy Contact** in writing at our office. You also may complain to the Secretary of U.S. Department of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

Changes in Policy:

I reserve the right to change its Privacy Policy based on the needs of my Practice and changes in state and federal law.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket:

You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI:

You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Right to Opt out of Fundraising Communications:

You have a right to decide that you would not like to be included in fundraising communications that I may send out.