

## NOTICE OF PRIVACY PRACTICES

Your health information is important to us and we have adopted strict policies to ensure that it remains confidential. In most cases, we must have written consent from you to release health information to an outside individual or agency. **Protected Health Information** is information about you, your health status and your medical care that is maintained by this office. This may include demographic information, treatment records, evaluation reports and medical records received from other sources. This notice explains how **Atlanta Psychiatric Specialists PC** and its employees may use and disclose information we maintain about you. It also explains your rights regarding this information.

**By consenting to receive treatment from this office, you allow us to use your health information in the following specific ways unless you request in writing for us to limit these disclosures:**

- **For Payment:** We may use and disclose health information about you, such as your diagnosis and treatment plan, to secure payment for your treatment received at this office. This includes payment made by a worker's compensation plan.
- **For Treatment.** We may use your health information to provide you with medical care or to recommend treatment alternatives. Office personnel may also disclose limited health information to an outside source in order to directly coordinate your care (such as securing authorizations through an insurance company or coordinating a referral to another medical provider)
- **Within a Treatment Setting:** We may also disclose certain information in a treatment setting if we receive verbal authorization. For example, we may disclose personal health information to your spouse if you bring your spouse with you into the treatment room.

We may use or disclose information about you **without your consent** for the following purposes, subject to applicable state and federal laws. **Where appropriate, we will make every effort to notify you prior to releasing information in these contexts:**

- To avert a serious threat to your health or safety, or to avert a serious public health risk.
- To a coroner, medical examiner, or funeral director to assist in identifying a deceased person or identifying the cause of death
- To health oversight agencies for audits, investigations, inspections, or licensing purposes
- To law enforcement or other legal entities in response to a court order, subpoena or similar process
- To military, national security and intelligence agencies (if you were part of one of these agencies) when we are legally required to do so.
- To organ and tissue donation agencies (if you are an organ or tissue donor) to facilitate organ or tissue transplants.
- To public health agencies in order to prevent or control disease or injury or to report certain medical events such as birth defects or adverse reactions to medications.

**We may also disclose limited health information to a relative or friend if we can infer, based on our professional judgment, that failure to do so may result in serious harm to you.**

**Health information that does not identify you:** We may use or disclose health information about you in a way that does not personally identify you. For example, this information may be used to evaluate our services or to comply with certain government regulations that monitor the healthcare system. In some cases, this information may be provided to another agency.

**Use of health information for research:** We may use and disclose health information about you, with your consent, for research projects that are subject to a special approval process.

**Ross F. Grumet, MD**

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**New Patient  
Paperwork**

**Your rights:** You have the following rights regarding the use of your health information:

- Right to inspect and copy certain portions of your records
- Right to amend information that you think is incomplete or inaccurate
- Right to an accounting of disclosures of your healthcare information
- Right to file a complaint if you feel your privacy rights have been violated
- Right to request restriction on disclosure
- Right to request confidential communications
- Right to revoke consent to release information at any time

**Please note:** Federal law has placed restrictions on access (including patient access) to mental health, substance abuse records and records relating to diagnosis and treatment of HIV/AIDS and we will comply with regulations applicable to your records. If we decline to release your health information, you may ask that the denial be reviewed by an independent agent and we will comply with that agent's decision.

**Limitations on Disclosure:** If you wish to limit disclosure of your health information, you must make this request in writing. We will comply with all reasonable requests unless the information is needed to provide you emergency treatment.

**Other Uses and Disclosure of Health Information:** We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization.

**Please sign below to acknowledge that this information has been made available to you. If you have questions regarding this form, please speak with a member of the staff *before* signing this form.**

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

You may revoke this consent at any time by giving us written notice. Any revocation will apply only to future uses of your health information, and is not applicable to any information that has already been released.