

Yaron M. Peer, LCSW
1133 Broadway
5th Floor, Suite 521
New York, NY 10010
(347) 762-2713

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA), this notice describes how your health information may be used/disclosed and how to obtain access to your individually identifiable health information.

Commitment to Your Privacy:

A. **My practice is dedicated to maintaining the privacy of your PHI.** I am legally required to keep records regarding you and the services provided. I am required by law to maintain the confidentiality of health information that identifies you. I am also required by law to provide you with this notice of our legal duties and the privacy practices I maintain in my practice concerning your PHI. By federal and state law, I must follow the terms of the Notice of Privacy Practices that we have in effect at the time. This notice is to provide you with the following important information:

- How I may use/disclose your PHI
- Your privacy rights in your PHI
- My obligations concerning your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by my practice. Please note I reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that my practice has created or maintained in the past, and for any of your records that I may create or maintain in the future. In the case that changes are made to my policies, I will immediately notify you and you may request a copy of this notice or view a copy of it in my office.

B. **I may use/disclose your PHI the following ways:**

- **For Treatment:** I may disclose your PHI to other licensed health care providers involved with your care to coordinate treatment.
- **For Payment:** I may use and disclose your PHI in order to collect payment. I may contact your health insurer to certify you are eligible for benefits and I may provide your insurer with details regarding your treatment to determine if treatment will be covered. I may also use and disclose your PHI to obtain payment from third parties responsible for such costs or to bill you directly. Lastly, I may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
- **For Health Care Operations:** I may use and disclose your PHI to facilitate the efficient and correct operation of my practice. For example, I might use your PHI in the evaluation of the quality of health care services that you have received for quality assurance. I may also provide your PHI to my attorneys, accountants, consultants, and others to ensure that I am in compliance with applicable laws.

- **For Legally Required Disclosures:** I will use and disclose your PHI when required to do so by federal, state or local law.
- **Other Necessary Disclosures:** Your consent is not required if emergency treatment is necessary. However, I must attempt to obtain your consent after treatment is rendered. Should you be unable to communicate while I am trying to obtain your consent (for example, if you are unconscious or in severe pain), I may disclose your PHI if I think you would consent to such treatment if you could.

C. **Use/disclosure of PHI In special circumstances:** The following categories describe unique scenarios in which I may use/disclose your identifiable health information without your consent or authorization:

- **To avoid harm:** I may provide PHI to law enforcement staff able to prevent or mitigate a serious threat to the safety of a person or the public. Disclosure is permitted or mandated if you are in a mental/emotional condition considered dangerous to yourself or others and I determine disclosure is necessary to prevent threatened danger. Additionally, disclosure is mandated by child abuse and neglect reporting laws in New York State if I have a reasonable suspicion of child abuse or neglect. Disclosure is also mandated by elder/dependent adult abuse reporting laws in New York State if I have a reasonable suspicion of elder abuse or dependent adult abuse. If I learn of a serious/imminent threat of physical violence by you against a reasonably identifiable victim(s), disclosure is also permitted.
- **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.**
- **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
- **If disclosure is compelled by the client or the client's representative pursuant to New York Health & Safety Codes or to corresponding federal statutes of regulations.**
- **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
- **For public health activities.** For example, in the event of your death, if disclosure is permitted or compelled, I may need to give the county coroner information about you.
- **For specific government functions.** For example, I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
- **For research purposes.** I may provide PHI in order to conduct research.
- **For health oversight activities.** I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
- **For Worker's Compensation purposes.** I may provide PHI in order to comply with Worker's Compensation laws.
- **For Appointment Reminders.**
- **To advise you of health related benefits or alternate services available.**
- **If an arbitrator or arbitration panel compels disclosure.** Arbitration may lawfully request PHI pursuant to a subpoena (e.g. a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding.
- **If disclosure is required or permitted to a health oversight agency for oversight activi-**

ties authorized by law. For example, when compelled by the U.S. Secretary of Health & Human Services to investigate or assess my compliance with HIPAA regulations.

- **If disclosure is otherwise specifically required by law.**

D. Your rights regarding your PHI:

- **Confidential communications.** You have the right to request my communication with you regarding your health and related issues in a particular manner or at a certain location. I will accommodate reasonable requests with no explanation required.

- **Requesting restrictions.** You have the right to request a restriction in our use or disclosure of PHI for treatment, payment or health care operations. You also have the right to request I restrict disclosure of your PHI to only certain individuals involved in your care or the payment for your care. If such a request is agreed upon, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

- **Inspection and copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about your care, including patient medical records and billing records, but not including psychotherapy notes. Requests must be submitted in writing in order to inspect and/or obtain a copy of your PHI. You will receive a response within 30 days of my receiving your written request. Under certain circumstances, I may deny your request; however, a written explanation of my clinical reasoning will be provided. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will not charge you more than \$0.25 per page.

- **Amendment.** You may ask me to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for my practice. A request must be made in writing and submitted. You must provide a reason that supports your request for amendment. I may deny your request if asked to amend information that is in my opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by my practice, unless the individual or entity that created the information is not available to amend the information.

- **Accounting of disclosures.** All clients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures I have made of your PHI for purposes not related to treatment, payment or operations. It is not required to document use of your PHI as part of routine patient care. In order to obtain an accounting of disclosures, you must submit your request in writing. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but I may charge you for additional lists within the same 12-month period. I will notify you of the costs involved with additional requests and you may withdraw your request before you incur any costs.

- **Right to a paper copy of this notice.** You are entitled to receive a paper copy of my notice of privacy practices at any time.

- **Right to file a complaint.** If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you.

If you have any questions regarding this notice or our health information privacy policies, please contact Yaron M. Peer, LCSW at: 347-762-2713.

This notice went into effect on March 1st 2020.

I acknowledge receipt of this HIPAA notice:

Client Name (printed): _____

Signature: _____

Date: _____