CAROLINA COMPLETE PSYCHIATRY

PRIVACY POLICIES

This notice describes how medical information about you may be used and disclosed and your access to it. Protected health information about you is obtained as a record of your visits or contacts with Carolina Complete Psychiatry, PLLC for healthcare services. Specifically, PROTECTED HEALTH INFORMATION is information about you, including demographic information (name, address, age, etc.) that may identify you and may relate to your past, present and/or future physical or mental health condition(s) and related healthcare services. Carolina Complete Psychiatry, PLLC is required to follow specific rules for maintaining the confidentiality of your protected health information, the use of your information and how providers disclose or share this information to/with other healthcare professionals involved in your care and treatment. This Policy describes your rights to access and control your protected health information. It also describes how we follow those rules in the use and disclosure of your protected health information for the purposes of providing treatment, obtaining payment for the services you receive, managing our healthcare operations and for other purposes permitted/required by law.

YOUR RIGHTS UNDER THE PRIVACY RULE:

The following is a statement of your rights under the Privacy Rule in reference to your protected health information. Please feel free to discuss any questions/concerns with the staff.

YOUR RIGHTS TO A COPY OF PRIVACY POLICIES

We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain. Upon request, you will be provided with a revised Notice of Privacy Policies.

YOUR RIGHTS TO AUTHORIZE OTHER USE AND DISCLOSURE

This means that you have the right to authorize or deny authorization for any other use/disclosure of protected health information not specified in this notice. You may revoke an authorization at any time except to the extent that Carolina Complete Psychiatry, PLCC has taken an action in reliance on the use or disclosure indicated in the authorization. Any revocation of authorization to use or disclose protected health information must be presented in writing.

YOUR RIGHTS TO DESIGNATE A PERSONAL REPRESENTATIVE

This means that you may designate a person who then has the delegated authority to consent to or authorize the use or disclosure of your protected health information. Any notice of revocation of authorization/designation of a previously named personal representative must be presented in writing.

YOUR RIGHTS TO YOUR PROTECTED HEALTH INFORMATION

This means that you may inspect and obtain a copy of protected health information about you that is contained in your patient record. Under certain circumstances, we may deny your request. Any requests for copies of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

This means that you may request, in writing, that we not disclose any part of your protected health information for the purposes of treatment, payment for service you have received, or healthcare operations. You may also request that any part of your protected health information be restricted from disclosure to others who may be involved in your care or for notification purposes as described in this Notice of Privacy Policies. Under certain circumstances, we may deny your request for restriction. All requests for restriction of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST YOUR PROTECTED HEALTH INFORMATION AMENDED

This means that you may request an amendment of your protected health information for as long as we maintain the information. Under certain circumstances, we may deny your request for an amendment. All requests for amendment to your protected health information must be made in writing.

PRIVACY POLICY AUTHORIZATION

You have certain rights regarding your protected health information under the Health Insurance Portability and Accountability Act (HIPPA). This document allows you to specify under what conditions your protected health information may be used or disclosed. HIPAA gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI).Please initial what type(s) of information and for what purpose(s) you authorize us to disclose your protected health information.

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Carolina Complete Psychiatry, PLLC. A copy of this signed, dated document shall be as effective as the original. A current copy of the privacy policy may be found at www.ccpsychiatry.com.

_____ Date of Birth: _____

Printed Name of Patient

_____

Signature (and relationship if patient is a minor)

Date Updated: 11/30/2016