

NOTICE OF PRIVACY PRACTICES

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

I. Who is Subject to This Notice

Elaine F. Mateo, M.D.

II. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

- Maintain the privacy of your health information as required by law;
- Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
- Follow the terms of our Notice currently in effect.

III. Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person:

**Privacy Officer
5605 Glenridge Drive Building 1 Suite 600
Atlanta, GA 30342
(404) 448-3394**

IV. Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. However, the American Psychiatric Association's Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal health information. Participants in this organized health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.

V. Other Uses and Disclosures

In addition to uses and disclosures related to treatment, payment, and health care operations, we may also use and disclose your personal information without authorization for the following additional purposes.

Abuse, Neglect, or Domestic Violence

- As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Business Associates

- We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to service and maintain our computer systems, or do our billing. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

Communications with Family and Friends

- We may disclose information about you to persons who are involved in your care or payment for your care, such as family members, relatives, or close personal friends. Any such disclosure will be limited to information directly related to the person's involvements in your care.

Food and Drug Administration (FDA)

- We may disclose health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.

Health Oversight

- We may disclose health information about you for oversight activities authorized by law or to an authorized health oversight agency to facilitate auditing, inspection, or investigation related to our provision of health care, or to the health care system.

Judicial or Administrative Proceedings

- We may disclose health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations.

Law Enforcement

- We may disclose health information about you to a law enforcement official for certain law enforcement purposes. Such disclosure will only occur when required by law.

Minors

- If you are an unemancipated minor under Georgia law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

Notification

- We may notify a family member, your personal representative, or other person responsible for your care, of your location, general condition, or death.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of

some other emergency circumstance , we will use our professional judgments to determine what is in your best interest regarding any such disclosure.

- You have the right to be notified in the event of a breach of the privacy or security of your Protected Health Information.

Parents

- If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.
- In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Personal Representative

- If you are an adult or unemancipated minor, we may disclose health information about you to a personal representative authorized to act on behalf in making decisions about your health care.

Public Health Activities

- As required or permitted by law, we may disclose health information about you to a public health authority, for example, to report disease, injury, or vital events such as death.

Public Safety

- Consistent with our legal and ethical obligations, we may disclose health information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to public.

Required By Law

- We may disclose health information about you as required by federal, state, or other applicable law.

Research

- We may disclose health information about you for research purposes in accordance with our legal obligations. For example, we may disclose health information without a written authorization if an Institutional Review Board (IRB) or authorized privacy board has reviewed the research project and determined that the information is necessary for the research project and determined that the information is necessary for the research and will be adequately safeguarded.

Specialized Government Functions

- We may disclose health information about you for certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veterans' benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.

Worker's Compensation

- We may disclose health information about you for purposes related to workers' compensation, as required and authorized by law.

VI. Your Health Information Rights

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- Request electronic copies of information held electronically.
- Restrict disclosure of encounter information to an insurer, including Medicare if it is paid fully out of pocket by the individual.
- Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.
- Request that we communicate with you by alternative means, such as making records available for pick-up, mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.
- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.
- Request that we amend the health information about you that we maintain in our files and the files of our business associates (if applicable). Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.
- Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not necessarily include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested (for example, "from May 1, 2003 to June 1, 2003"). We will be unable to provide you an accounting for any disclosures made before April 14, 2003 or for a period of longer than six years.
- Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section III above for information). If you have questions about your rights, please speak with me in person or by phone.

VII. To Request Information or File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to the office. You may complain to the Secretary of Health and Human Sciences (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-(800) 368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint as a condition of receive care from us, or penalize you for filing a complaint with HHS.

VIII. Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area of the office, make copies available to patients and others.

IX. Effective Date

September 23, 2013

Patient Name: _____ **Birth date:** _____

Maiden or other name (if applicable): _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Elaine F. Mateo, M.D., effective September 23.2013.

Signature (patient or authorized representative): _____

Date: _____

Relationship/authority (if signed by authorized representative): _____

Authorization to Use/Disclose Health Care Information

Patient Name: _____ **Birth date:** _____

Maiden or other name (if applicable) _____

I request and authorize _____ to release the health care information described below to:

Name: _____ **at** _____

Address: _____

City, State: _____ **Zip code:** _____

This request and authorization applies to only the following protected health information:

- | | |
|---|--|
| <input type="checkbox"/> Initial Psychiatric Evaluation | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Psychiatric Reports/Tests | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other _____ |

During the following time period or dates: _____

Each disclosure made with the patient’s written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

Purpose(s) of this use/disclosure: _____

Authorization expires: _____ (date or event, e.g., “end of research study”)

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Elaine F. Mateo, M.D.

I understand that Dr. Mateo may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations.

Signature (patient or authorized representative) _____

Date: _____

Relationship/authority (if signed by authorized representative): _____

I have received a copy of this signed authorization: (please initial) ___ Yes ___ No