Maxwell Rovner, M.D. S.C.
Adult Psychiatry
30 N. Michigan Ave, suite 1004 Chicago, IL 60602
Tel: (312) 508-3475
Fax: (312) 275-7955
www.DrMaxwellRovner.com

NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how psychiatric and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Privacy is a very important concern for all those who come to my office. This Notice of Privacy Practices describes how I protect your personal health information (PHI), details how I may use and disclose your clinical information, and explains certain rights you have regarding this information. I am providing you with this notice in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and I will comply with the terms as stated. I will obey the rules of this notice as long as it is in effect. You can obtain a copy from me at any time, and it will be posted on my website.

I. HOW I USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

I protect your personal health information from inappropriate use and disclosure. Your information is obtained in the course of providing services to you and is related to your medical records, psychotherapy visits, and payment information. It is likely to include your history, reasons you came for psychotherapy, diagnoses, progress notes I make, records I get from others who worked or work with you, and billing and insurance information. I will not disclose any personal health information without your written authorization, unless such disclosure is permitted or required by law.

Uses of your personal health information requiring your consent:

I may use or disclose your protected health information (PHI), for treatment, payment, appointment reminders and healthcare operations purposes with your consent. To help clarify these terms, definitions are provided below:

- ***PHI*:** refers to information in your health record that could identify you.
- ***Treatment*:** is when I provide, coordinate or manage your healthcare and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your primary care physician.
- ***Payment*:** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
- ***Appointment Reminders*:** are when I use and disclose medical information to contact and remind you about appointments. If you are not home, I may leave this information on your

voicemail or in a message left with the person answering the phone. I may also send appointment reminders via email or text.

- ***Healthcare Operations*:** are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters, and case management and care coordination.
- ***Use*:** applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- ***Disclosure*:** applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

Uses of your personal health information requiring authorization:

I may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. An **authorization** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and healthcare operations, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided that each revocation is in writing. You may not revoke authorization to the extent that: (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and law provides the insurer the right to contest the claim under the policy.

Uses of your personal health information not requiring your consent or authorization:

When disclosing your personal health information is required by law, I will use and disclose your health information, but I will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, I will further comply with the requirement set forth below concerning those activities.

The following are circumstances in which I may use or disclose PHI *without* your consent or authorization:

- ***Child Abuse*:** If I, in my professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him/her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, I must immediately report this information to the Illinois Department of Social Services.
- ***Adult and Domestic Abuse*:** If I have reasonable cause to believe that an elderly person (age 60 or older) is suffering from or has died as a result of abuse, I must immediately make a report to the Illinois Department of Elder Affairs.

- ***Health Oversight*:** The Board of Registration of Medicine has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.
- ***Judicial or Administrative Proceedings*:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative or court-order. The privilege does not apply when you is being evaluated by a third party or when the evaluation is court-ordered. You will be informed in advance if this is the case.
- ***Serious Threat to Health or Safety*:** If you communicate to me an explicit threat to kill or inflict bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. This may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you have a history of physical violence and I believe that there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to self and refuse to accept further, appropriate treatment, and I have a reasonable basis to believe that you require hospitalization, I must seek commitment to a hospital and may contact your family members or other individuals if it would assist in protecting you.
- ***Worker's Compensation*:** If you file a worker's compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

Use of your psychotherapy notes:

I will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training my staff, students and other trainees, (3) to defend myself if you sue or bring some other legal proceeding, (4) if the law requires me to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, I will stop using or disclosing these notes.

II. YOUR HEALTH INFORMATION RIGHTS

1. **Right to request restrictions:** You have the right to request restrictions on certain uses and disclosures of PHI about you. I reserve the right to accept or reject any restriction request, and will notify you of my decision.

2. Right to receive confidential communications by alternative means and at alternative locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member

to know that you are seeing me. Upon your request, I will send your statements to another address.

3. Right to inspect and copy: You have the right to inspect or obtain a copy of your PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny you access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss the details of the request and denial process with you.

4. Right to amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

5. Right to accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section I of this Notice). On your request, I will discuss with you the details of the accounting process.

6. Right to a paper copy: You have the right to obtain a paper copy of the notice from me upon request.

III. PSYCHIATRIST'S DUTIES

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

3. If I revise my policies and procedures, I will provide you with the revised copy in person or by mail.

IV. COMPLAINTS

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to Dr. Rovner.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights, U.S. Department of Health and Human Services
233 N. Michigan Ave. - Suite 240 Chicago, IL 60601
Phone: (312) 886-2359; TDD: (312) 353-5693; Fax: (312) 886-1807

Maxwell Rovner, M.D. S.C.
Adult Psychiatry
30 N. Michigan Ave, suite 1004 Chicago, IL 60602
Tel: (312) 508-3475
Fax: (312) 275-7955
www.DrMaxwellRovner.com

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

V. EFFECTIVE DATE, RESTRICTIONS AND CHANGES TO PRIVACY POLICY

This Notice will go into effect on March 15, 2017. I reserve the right to change the terms of this Notice and make the new Notice provisions effective for all PHI I maintain. I will provide you with a revised Notice in person or by mail.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and clinician certifications

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Dr. Maxwell Rovner at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient's Name _____

Patient's/Patient's Guardian's Signature _____

Date _____