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## **Notice of Psychiatrists' Policies and Practices to Protect the Privacy of Your Health Information**

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

*I understand the importance of privacy and am committed to maintaining the confidentiality of your medical information. I make a record of the medical care I provide and may receive such records from others. I use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable me to meet my professional and legal obligations to operate this practice properly. I am required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how I may use and disclose your medical information. It also describes your rights and my legal obligations with respect to your medical information. If you have any questions about this Notice, please contact me.*

### **I. Disclosures for Treatment, Payment, and Health Care Operations**

I may use or disclose your protected health information (PHI), for certain treatment, payment, and health care operations purposes without your authorization. In certain circumstances I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
  - Treatment is when I or another healthcare provider diagnoses or treats you. An example of treatment would be when I consult with another healthcare provider, such as your family physician or another psychiatrist or therapist, regarding your treatment.
  - 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 health care or to determine eligibility or coverage.
  - Health Care Operations is when I disclose your PHI to your health care service plan (for example your health insurer), or to other health care providers contracting with your plan, or administering the plan, such as case management and care coordination.
- “Use” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- “Authorization” means your written permission for specific uses or disclosures.

### **II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until I receive it.

### **III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

**Treatment:** I use PHI to provide your mental health care. For example, I may share your PHI with other physicians or other health care providers who will provide services that I do not provide or who provide you with additional services. I will only communicate with these providers with your written consent (unless I judge that the communication is necessary to maintain the safety of you or others).

**Required by Law:** As 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 me 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.

**Child Abuse:** Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect, has been the victim of child abuse or neglect, I must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, I may report such to the above agencies.

**Adult and Domestic Abuse:** If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the adult protective services agency or the local law enforcement agency.

I do not have to report such an incident if:

- 1) I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;
- 2) I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;
- 3) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and
- 4) in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

**Health Oversight:** If a complaint is filed against me with a court of the law or with the Medical Board of California, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

**Serious Threat to Health or Safety:** If you or your family member communicates to me that you pose a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

**Workers' Compensation or Disability Claims:** I may disclose your health information as necessary to comply with workers' compensation laws or disability claims. For example, to the extent your care is covered by workers' compensation, I will make periodic reports to your employer about your condition. I am also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

**Appointment Reminders:** I may use and disclose your PHI to contact and remind you about appointments. If you are not home, I may leave this information on your answering machine or may provide the reminders via an email address that you provide to me.

**Waiting Room:** I may use and disclose medical information about you by calling out your first name when I am ready to meet with you.

**Payment:** I use and disclose medical information about you to obtain payment for the services I provide. I also use credit card processing companies that can access the financial information that you provide by choosing this form of payment.

**Public Health:** I may, and am sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; and reporting child, elder or dependent adult abuse or neglect. When I report suspected elder or dependent adult abuse or domestic violence, I will inform you or your personal representative promptly unless in our best professional judgment, I believe the notification would place you at risk of serious harm or would require informing a personal representative I believe is responsible for the abuse or harm.

**Judicial and Administrative Proceedings:** I may, and am sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. I may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order. If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

**Coroners:** I may, and am often required by law, to disclose your health information to coroners in connection with their investigations of deaths. I will do my best to maintain confidentiality, within the bounds of the law, upon your death.

**Change of Ownership:** In the event that this medical practice is sold or merged with another organization, or in the case that I become incapacitated or die, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another mental health provider.

#### **IV. When This Medical Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**Your Health Information Rights**

**Right to Request Special Privacy Protections:** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell me not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, I will abide by your request, unless I must disclose the information for treatment or legal reasons. I reserve the right to accept or reject any other request, and will notify you of our decision.

**Right to Request Confidential Communications:** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that I send information to a particular e-mail account or to your work address. I will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

**Right to Inspect and Copy:** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. I will provide copies in your requested form and format if it is readily producible, or I will provide you with an alternative format you find acceptable, or if I can't agree and I maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. I will also send a copy to any other person you designate in writing. I will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. I may deny your request under limited circumstances. If I deny your request to access your child's records or the records of an incapacitated adult you are representing because I believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If I deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

**Right to Amend or Supplement:** You have a right to request that I amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. I am not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. I may deny your request if I do not have the information, if I did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If I deny your request, you may submit a written statement of your disagreement with that decision, and I may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

**Right to an Accounting of Disclosures:** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

**Right to a Paper or Electronic Copy of this Notice:** You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, you may contact me.

**V. Changes to this Notice of Privacy Practices**

I reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, I am required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that I maintain, regardless of when it was created or received. I will keep a copy of the current notice posted on my website and printed copies will be available upon request.

**VI. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: [OCRMail@hhs.gov](mailto:OCRMail@hhs.gov). The complaint form may be found at [www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf](http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf). You will not be penalized in any way for filing a complaint.

**VII. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice is effective as of November 10, 2014. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain.