NOTICE OF PRIVACY PRACTICES
CLEARINSIGHT PSYCHIATRY, Inc.

PLEASE REVIEW THIS NOTICE CAREFULLY AND SIGN BELOW

ClearInsight Psychiatry, Inc is required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. This information consists of all records related to your health, including demographic information, either created by ClearInsight Psychiatry, Inc or received from other healthcare providers. Our primary responsibility is to safeguard your personal health information. We must inform you of this notice of our privacy practices, and follow the terms of the notice currently in effect. We will notify you in the event we become aware of unauthorized access, use or disclosure of your unsecured protected health information.

Uses and Disclosures Requiring Authorization
ClearInsight Psychiatry, Inc may use or disclose your protected health information for purposes outside of treatment, payment, and health care operations when the appropriate authorization is obtained. In those instances ClearInsight Psychiatry, Inc. will obtain an authorization from you before releasing this information. We may not disclose your protected health information to your family members or friends who may be involved in your care without your verbal or written permission.

Situations Requiring Your Verbal Agreement
Your personal information changes, such as your name, home address, insurance information.

Situations Requiring Your Written Authorization
If there are reasons we have not been described in the sections above, we will obtain your written permission. This permission is described as an "authorization." If you authorize us to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer disclose health information for the reasons stated in your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care we provide to you.

Uses and Disclosures of Your Protected Health Information Not Requiring Your Consent:
ClearInsight Psychiatry, Inc may use and disclose your protected health information, without your written authorization, for certain treatment, payment and healthcare purposes. These include, but are not limited to:
· Providing, coordinating, or managing healthcare and related services by one or more healthcare providers,
· Referrals to other providers or health agencies for treatment,

· Activities undertaken by ClearInsight Psychiatry, Inc to obtain reimbursement for services provided to you,
· Health information may be released without written permission to a parent's guardian, or legal custodian of a child, guardian of an incompetent adult, the public conservator, the healthcare agent designated power of attorney for an incapacitated patients, or the representative or spouse of a deceased patient.
· If you are a member of the armed forces, we may release health information about you as required by military command authorities.
·We disclose health information about you without your permission when required to do so by federal, state or local law.

Other situations when ClearInsight Psychiatry, Inc is permitted to disclose your protected health information without your consent or authorization or call a proper authority to insure your safety, others' safety include but not limited to the following:
· You have shown signs of hurting yourself and others,
· When required by law, for example reporting abuse, neglect, domestic violence, or injuries believed to occur as a result of crime,
· For public health reasons, we are required to report certain infectious diseases to public health authorities.

It is our practice to use your information to contact you with appointment reminders. We may also contact you with information about treatment alternatives and services that may be of interest to you. You must notify us if you do not wish to receive appointment reminders or contact in regards to certain treatment alternatives and services.

You have the right to examine your own health record within 5 working days of our receipt of your written request. You have the right to obtain a copy of your own health record within 15 days of our receipt of your written request and payment. You also have the right to request corrections in your medical record.

Note: This notice is prepared in accordance with the Health Insurance Portability and Accountability Act (HIPAA) 45 C.F.R. 164.520.

Notice to consumers: Medical Doctors are licensed and regulated by the Medical Board of California. (800) 633-2322, www.mbc.ca.gov.

With my signature, I hereby acknowledge receipt of the Notice of Privacy Practices given to me.

*Patient Signature_____Date:_____

*Print Name:_____