DR. LADAN GOBLE

14300 N. Northsight Blvd. Ste 129 • Scottsdale, AZ 85260 • (P) 480-661-3877 • (F) 480-661-3878

HIPAA PRIVACY POLICY ACKNOWLEDGMENT/AGREEMENT

This notice describes how your medical information, as a patient of **Psychiatry of Scottsdale, PLLC**, may be used and disclosed, as well as how you may obtain access to your health information. This is required by the Privacy Regulations created as a result of the "Health Insurance Portability and Accountability Act" of 1996 (HIPAA).

Commitment to Privacy: Your physician is dedicated to maintaining the privacy of your health information. It is required by law to maintain confidentiality of your health information. It is required by law that you are provided with the following information:

Use and disclosure of your health information in certain special circumstances may be required:

1. To public authorities and health oversight agencies authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. IF required to do so by a law enforcement official.
4. When necessary to reduce or prevent serious threat to your health or to the health and safety of another individual or the public. Disclosure will only be made to a person or an organization able to help prevent the threat and protect from harm.
5. If you are a member of the US or a foreign military force (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

Your rights regarding your health information:

1. Communication: You may request communication about your health and related issues in a particular manner or at a certain location (i.e., you may request to be contacted at home rather than work). Reasonable requests will be accommodated to the best of your physician's ability.
2. Restrictions: You may request restrictions in disclosure of your health information for treatment, payment, or information to only certain individuals involved in your care or payment of care (i.e., family, spouse, friend). It is not required of your physician to agree to your request; however, if such agreement is made, your physician is bound to the agreement, except when otherwise required by law or when information is necessary to treat you.
3. Medical Records: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including medical records and billing records, but not including psychotherapy notes. You must submit a written request to your physician at:
   14350 N. FRANK LLOYD WRIGHT BLVD, ST. 8 SCOTTSDALE, AZ 85260 (P) 480-661-3877 (F) 480-661-3878

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4. Amendments: You may request that your medical information be amended if you believe it to be incorrect or incomplete, and as long as the information is kept for your physician. To request an amendment, you must submit a written request to your physician at: **14350 N. FRANK LLOYD WRIGHT BLVD, ST. 8 SCOTTSDALE, AZ 85260 (P) 480-661-3877 (F) 480-661-3878**

   Grievances: You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with your physician or with the Secretary of the Department of Health and Human Services. To file a complaint, please submit a written request to your physician at**: 14350 N. FRANK LLOYD WRIGHT BLVD, ST. 8 SCOTTSDALE, AZ 85260 (P) 480-661-3877 (F) 480-661-3878**
   Please note you will not be penalized for filing a complaint.
5. Right to copy of notice: You are entitled to receive a copy of this Notice of Privacy Policies and may simply request a copy from your physician or physician's support staff.
6. Right to provide authorization for other uses and disclosures: Your physician will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have questions regarding this notice or Health Information Privacy Policies, please contact your physician at 480-661-3877. Please sign this form once you have read and acknowledged receipt of this information. Thank you.

I, _____, acknowledge that I have received a copy of the **Psychiatry of Scottsdale, PLLC's HIPPA Privacy Policy**. I understand that the notice describes how my protected health information may be used and disclosed, provides information regarding certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my health information.

_____ _____

Patient/Guardian Signature Date

_____

Patient/Guardian Printed Name