Heart Space Psychology Inc.
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NOTICE OF USE OF PRIVATE HEALTH INFORMATION

Effective Date: April 14, 2003

FOR YOUR PROTECTION

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

YOUR HEALTH INFORMATION IS PRIVATE

Keeping your health information private is one of our most important responsibilities. We are committed to protecting your health information and following all laws regarding the use of your health information. The laws say:

1. We must keep your health care information from others who do not need to know it.
2. You may ask that we not share certain health information. (In some instances we may not be able to agree with your request.)

WHO SEES MY HEALTH INFORMATION?

Your private health information may be used by the health care providers (such as substance abuse treatment counselors, mental health providers, doctors, nurses, etc.) who take care of you. We need this information in order to plan your care. When appropriate we may share health information about you in order to help you get the services you need. We may also use your information to contact you about appointment reminders or to tell you about treatment alternatives.

MAY I SEE MY HEALTH INFORMATION?

You may see your health information unless it is the private notes taken by a mental health provider or it is part of a legal case. Most of the time you may receive a copy if you ask. You may be charged an amount to cover copy costs.

If you think some of the information is wrong, you may ask in writing that it be changed or that new information be added. You may ask that the changes or new information be sent to others who have received your health information from us. You may ask for a list of any places where health information has been sent, unless it was sent for treatment, payment, quality review, or to make sure we are following the laws protecting your privacy.

WHAT IF MY HEALTH INFORMATION NEEDS TO GO SOMEWHERE ELSE?

You may be asked to sign an authorization form allowing your health care information to go somewhere else if:

1. Your health care provider needs to send it to other places;
2. You want us to send it to another health care provider; or

3. You want it sent to another person for you.

The authorization form tells us what, where and to whom the information must be sent. Your authorization is good for six (6) months or until the date you put on the form. You can cancel or limit the amount of information sent at any time by letting us know in writing.
If you are less than 18 years old – your parents or guardians will receive your private health information, **unless by law you are able to consent for your own health care treatment**. If you are, then your private health information will not be shared with parents or guardians unless you sign an authorization form. You may also ask to have your health information sent to a different person that is helping you with your health care.

COULD MY HEALTH INFORMATION BE RELEASED WITHOUT MY AUTHORIZATION?
When private health information is released without an authorization, it is normally used for Treatment, Payment or Operations (managing the business of a health care provider and reporting to agencies that oversee our business, such as state regulators). The release of health information for this purpose is not tracked and we are not accountable to you for it. Any other release made without your authorization is tracked and accounted. We always report:

1. Contagious diseases, birth defects, and cancer
2. Reactions and problems with medicine
3. Victims of abuse, neglect or domestic violence
4. To the government agency that oversees our business
5. To prevent serious threat to your or others' health and safety
6. Work-related injuries
7. Out of state offenders
8. As required by court order and/or subpoena
9. If you commit a crime on the premises

HOW CAN I FIND OUT IF MY HEALTH INFORMATION HAS BEEN RELEASED WITHOUT MY AUTHORIZATION?
To find out if your health information has been released without your authorization for purposes other than Treatment, Payment or Operations, contact Rachel Negar Partiali, Ph.D. at 11301 West Olympic Blvd. #121-707 Los Angeles, CA 90064 and ask for a Request for Accounting of Disclosures form. Simply fill out the form, attach a copy of your most recent picture ID, and send both to: Rachel Negar Partiali, Ph.D. at 11301 West Olympic Blvd. #121-707 Los Angeles, CA 90064.

MAY I HAVE A COPY OF THIS NOTICE?
This notice is yours. If we change anything in it, you will get a new notice. You can obtain additional copies of this notice by asking your health care provider.

QUESTIONS OR COMPLAINTS?
If you have questions about this notice or you think that we have not protected your private health information and you wish to complain about it, please contact: Rachel Negar Partiali, Ph.D. at (310) 773-0037.

You can also complain to the Federal Government by writing to the:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201-0004
Or by calling the Office for Civil Rights at (800) 368-1019

By signing this form, you are acknowledging that you have received a copy of this notice.

_____ _____

Patient or Parent/Guardian's Signature Date

_____ _____

Therapist Signature Date