
NOTICE OF PRIVACY PRACTICE**Health Insurance Portability and Accountability Act (HIPAA)****PLEASE REVIEW THIS NOTICE CAREFULLY**

This notice describes how medical information about you may be used and disclosed and how you can get access to his information. Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services if referred to as "protected health information" (PHI) and for the purposes of this notice includes electronic PHI (ePHI). This notice of privacy practices describes how we may use and disclose your PHI in accordance with applicable laws and ethical standards. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this notice of privacy practices. We reserve the right to change the terms of our notice of privacy practices at any time. Any new notice of privacy practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised notice of privacy practices by posting a copy in our lobby, sending a copy to you in the mail at your request or by providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

FOR TREATMENT. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members associated with Desert Psychological. We may disclose PHI to any other consultant or third party provider only with your authorization.

FOR PAYMENT. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

FOR HEALTH CARE OPERATIONS. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g. billing) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teach purposes, PHI will be disclosed only with your authorization.

AS REQUIRED BY LAW. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the privacy (and/or security) rule.

WITHOUT AUTHORIZATION. The following is a list of categories of uses and disclosures permitted by HIPAA without an authorization. Applicable laws permit us to disclose information about you without your authorization only in a limited number of situations.

1. **Child abuse or neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse and/or neglect.
2. **Judicial and administrative proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
3. **Deceased patients.** We may disclose PHI regarding deceased patients as mandated by law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.
4. **Medical emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
5. **Family involved in care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
6. **Health oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.
7. **Law enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, and, for the purpose of identifying a suspect, connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
8. **Specialized government functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the department of state for medial suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
9. **Public health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

10. **Public safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
11. **Research.** PHI may only be disclosed after a special approval process.

VERBAL PERMISSION. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

WITH AUTHORIZATION. Uses and disclosure not specifically permitted by applicable law will be made only with your written authorization, which you may revoke at any time with written notice.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our privacy officer at:

Odyssey Wellness, ATTN: Dr. Sarah Ahmad, 3067 E Warm Springs Rd, Ste 100 Las Vegas, NV 89120. Office: 702-202-0000. Fax: 702-710-6521.

1. **Right of access to inspect and copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies (\$.65 per page).
2. **Right to amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the privacy officer if you have any questions.
3. **Right to an accounting of disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than once accounting in any 12-month period.
4. **Right to request restrictions.** You have the right to request a restriction of limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
5. **Right to request confidential communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
6. **Breach notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
7. **Right to a copy of this notice.** You have the right to a copy of this notice and any subsequent changes.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our privacy officer at : **Odyssey Wellness, ATTN: Dr. Sarah Ahmad, 3067 E Warm Springs Rd, Ste 100 Las Vegas, NV 89120 Office: 702-202-0000. Fax: 702-710-6521**, or with the Secretary of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201, or by calling (202) 619-0257. The entire federal laws regarding HIPAA can be found at: <http://www.hhs.gov/ocr/privacy/index.html>.

WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT

ACKNOWLEDGEMENT OF HIPAA/RIGHTS RECEIPT

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Odyssey Wellness’s Notice of Privacy Practices.

I acknowledge that I understand how Odyssey Wellness may access, use, and disclose my protected health information (PHI). I understand my rights in regards to my PHI and the legal duties of Odyssey Wellness to protect my PHI. I acknowledge that any questions I have regarding my protected health information have been addressed to my satisfaction.

I understand that I may request another copy of the Notice of Privacy Practices upon request or by visiting an Odyssey Wellness office and viewing a copy of the Notice of Privacy Practices in the lobby.

Client Name

Date

Signature

Date