

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

I. MY RESPONSIBILITIES:

I reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that I maintain. Any new Notice of Privacy Practices adopted will be posted on my website, droher.com, and will be made available upon request.

II. WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected health information (PHI) is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present or future physical or mental health or condition and related health care services.

III. USES AND DISCLOSURES OF INFORMATION:

Under federal law, I am permitted to use and disclose personal health information without authorization for treatment, payment and health care operations.

IV. WHAT DOES HEALTH CARE OPERATIONS INCLUDE?

Health care operations include activities such as communications among health care providers, conducting quality assessment and improvement activities; evaluating the qualifications, competence, and performance of health care professionals; training future health care professionals; other related services that may be a benefit to you such as case management and care coordination; contracting with insurance companies; conducting medical review and auditing services; compiling and analyzing information in anticipation of or for use in legal proceedings; and general administrative and business functions.

V. HOW IS MEDICAL INFORMATION USED?

I use medical records as a way of recording health information, planning care and treatment and as a tool for routine health care operations. Your insurance company may request information such as procedure and diagnosis information that I am required to submit in order to bill for treatment I provide to the patient. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules required of me. Patient records are also a valuable tool used by researchers in finding the best possible treatment for diseases and medical conditions. All researchers must follow the same rules and laws that other health care providers are required to follow to ensure the privacy of patient information. Information that may identify

patients will not be released for research purposes to anyone without written authorization from the patient or the patient's parent or legal guardian.

VI. HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS:

Medical information may be used to justify needed patient care services, (i.e., lab tests, prescriptions, treatment protocols, research inclusion criteria). I will use medical information to establish a treatment plan. I may disclose protected health information to another provider for treatment (i.e. referring physicians, specialists and providers, therapists, etc.).

I may submit claims to your insurance company containing medical information and I may contact their utilization review department to receive pre-certification (prior approval for treatment). I will submit only the minimum amount of information necessary for this purpose. However, it may be necessary to provide your Psychotherapy Notes and other PHI to your health insurance provider pursuant to my contractual obligation to that provider.

I may use the emergency contact information you provided to contact you if the address of record is no longer accurate. I may contact you to remind you of your appointment by calling you. I may contact you to discuss treatment alternatives or other health related benefits that may be of interest.

VII. WHY DO YOU HAVE TO SIGN A CONSENT FORM?

When you, as the patient or guardian of a patient, sign a consent form, you are giving me permission to use and disclose protected health information for the purposes of treatment, payment and health care operations. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records and other privileged categories of information which require a separate authorization. You will need to sign a separate authorization to have protected health information released for any reason other than treatment, payment or healthcare operations.

VIII. WHAT ARE PSYCHOTHERAPY NOTES?

Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the patient's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to

date. Psychotherapy notes exclude Progress Notes, as that term is defined under Arizona law by Arizona Administrative Code R4-6-101(45).

IX. WHAT IS PSYCHOSOCIAL INFORMATION?

Psychosocial information is information provided regarding your social history and counseling or psychiatric services you have received before treatment with me.

X. WHY DO YOU HAVE TO SIGN A SEPARATE AUTHORIZATION FORM?

In order to release patient protected health information for any reason other than treatment, payment and health care operations, I must have an authorization signed by the patient or the parent or guardian of the patient that clearly explains how they wish the information to be used and disclosed. The following are some examples of releases of information that require a separate authorization: Psychosocial information - use of information in scientific and educational publications, presentations and materials.

XI. CAN YOU CHANGE YOUR MIND AND REVOKE AN AUTHORIZATION?

You may change your mind and revoke an authorization, except (1) to the extent that I have relied on the authorization up to that point, (2) the information is needed to maintain the integrity of the research study, or (3) if the authorization was obtained as a condition of obtaining insurance coverage. All requests to revoke an authorization should be in writing.

XII. SHARING INFORMATION WITH BUSINESS ASSOCIATES:

There are some services provided through contracts with business associates. Examples include billing services and transcription services. When these services are contracted, we may disclose your health information to the business associate so that they can perform the job we have contracted them to do.

XIII. WHEN IS YOUR AUTHORIZATION/CONSENT NOT REQUIRED?

The law requires that some information may be disclosed without your authorization in the following circumstances:

- In case of an emergency.
- When there are communication or language barriers.
- When required by law.
- When there are risks to public health.
- To conduct health oversight activities.
- To report suspected child abuse or neglect or abuse/neglect to other disabled persons.
- To specified government regulatory agencies.
- In connection with judicial or administrative proceedings.

- For law enforcement purposes.
- To coroners, funeral directors, and for organ donation - In the event of a serious threat to health or safety.

XIV. YOUR PRIVACY RIGHTS:

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. You have the right to inspect and copy your health information. This means you may inspect and obtain a copy of your PHI that is contained in a designated record set for so long as I maintain the PHI. A designated record set contains medical and billing records and any other records that I use in making decisions about your healthcare. You may not however, inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact my office if you have questions about access to your medical record.

2. You have the right to request a restriction of your health information. This means you may ask me to restrict or limit the medical information we use or disclose for the purposes of treatment, payment, or healthcare operations. I am not required to agree to a restriction that you may request. I will notify you if I deny your request. If I do agree to the requested restriction, I may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting my office.

3. You have the right to request to receive confidential communications by alternative means or at alternative locations. I will accommodate reasonable requests. I may also condition this accommodation by asking you for an alternative address or other method of contact. I will not request an explanation from you as the basis for the request. Requests must be made in writing to my office.

4. You have the right to request amendments to your health information. This means you may request an amendment of PHI about you in a designated record set for as long as I maintain this information. In certain cases, I may deny your request for an amendment. If I deny your request, you have the right to file a statement of disagreement with my office and I may prepare a rebuttal to your statement and I will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact my office. Requests for amendment must be in writing.

5. You have the right to receive an accounting of disclosures of your health information. You have the right to request an accounting of certain disclosures of your PHI. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Privacy Notice. I am also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, to family or friends involved in your care, or certain other disclosures I am permitted to make without your authorization. The request for an accounting must be made in writing to my office. The request should specify the time period sought for the accounting. Accounting requests may not be made for periods of time in excess of six years.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

XV. WHAT IF I HAVE A QUESTION/ COMPLAINT?

If you have questions regarding your privacy rights, please contact your clinician. If you believe your privacy rights have been violated, you may file a complaint by contacting my office, or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. The address for the Secretary of the Department of Health and Human Services is:

Office of Civil Rights U.S. Department of Health and Human Services
Atlanta Federal Center
Suite 3B70 61 Forsyth St., S.W.
Atlanta, GA 30303-8909
(404) 562-7886 (phone)
(404) 562-7881 (fax)
(404) 331-2867 (TDD)