



Richard Senyszn, MD

Psychiatry for Adults

1260 River Acres

New Braunfels, TX 78130

830-730-5920, Fax. (888) 972-3955

HIPPA STATEMENT: PATIENT RIGHTS: HIPAA provides you with rights with regard to your clinical record and disclosures of PHI (Patient Health Information). These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records, and the right to request a paper copy of this Agreement.

SPECIAL SITUATIONS

We may use or disclose your protected health information in the following situations without your authorization:

AS REQUIRED BY LAW: We will disclose your protected Health Information when required to do so by international, federal, state, or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Disclosures, however, will be made only to someone who may be able to help prevent the threat.

BUSINESS ASSOCIATES: We may disclose Protected Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

ORGAN AND TISSUE DONATION: If you are an organ donor, we may use or release Protected Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

MILITARY AND VETERANS: If you are a member of the armed forces, we may release Protected Health Information as required by military command authorities. We also may release Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

WORKERS' COMPENSATION: We may release your Protected Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISK: We may disclose Protected Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products as required by the US Food and Drug Administration (FDA); notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contractions or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

HEALTH OVERSIGHT ACTIVITIES: We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.



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LAWSUITS AND DISPUTES: If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information required. Law Enforcement. We may release Protected Health Information if asked by a law enforcement official if the information is:

1) in response to a court order, subpoena, warrant, summons, legal proceeding or similar process; 2) limited information to identify or locate a victim, suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS: We may release Protected Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Protected Health Information to funeral directors as necessary for their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES: We may release Protected Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS: We may disclose Protected Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

INMATES OR INDIVIDUALS IN CUSTODY: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Protected Health Information to the correctional institution or law enforcement official.

This release would be made if necessary; 1) for the institution to provide you with health care, 2) to protect your health and safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding the Protected Health Information we have about you:

RIGHT TO INSPECT AND COPY: You have a right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records. To inspect and copy this Protected Health Information, you must make your request, in writing, to the practice's privacy officer. Under federal law, however, you may not 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 protected health information that is subject to law that prohibits access to protected health information. If you request either a copy or a prepared summary of the Protected Health Information, we reserve the right to charge a fee for the costs of copying, mailing or faxing your requested health information. We will generally respond to your request for health information within 30 days of receiving your request, unless your health information is not readily accessible, or the information is maintained in an off-site storage location. In certain very limited circumstances, we may deny you request to inspect and copy your Protected Health Information.



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RIGHT TO AMEND: If you feel that your Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the practice's privacy officer. In addition to this, you must provide a reason which supports this request. The law limits your ability to change or add to your Protected Health Information. We may deny your request for an amendment if it is neither in writing nor does it include a reason to support your request, if the Protected Health Information did not originate from our office, is not part of your Information that is kept at this practice, is not permitted for you to inspect or copy, or we deem it to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Any such statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for the information that is pertaining to the appropriate portion of your record. Under no circumstances, will we erase or otherwise delete original documentation in your Protected Health Information.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request a list of certain disclosures we made of your Protected Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing to the practice's privacy officer. Generally, we will respond to your request within 60 days of receiving your request unless additional time is needed. The law excludes from an accounting many of the typical disclosures, such as those made to care for you, to pay for your health services or where you had provided your written authorization to the disclosure. Your request must state the time period that you want to receive a list of disclosures which cannot be longer than six years, and may not include dates before April 14, 2003. Your request should indicate if you want this list to be printed or in electronic form. The first list you request within a 12-month period will be free, but we reserve the right to charge you a fee for any additional lists.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the practice's privacy officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. Any restriction that is approved will not affect any use or disclosure that we are legally required or permitted to make under the law. If the physician believes it is in your best interest to permit use and disclosure of your protected health information then this will not be restricted.

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 such as where we may contact you for appointment reminders, lab results or other related information. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to our practice's privacy officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of the current notice, please notify the practice's privacy officer.



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CHANGES TO THIS NOTICE: We reserve the right to change the terms of this notice and make the revised or changed notice apply to your Protected Health Information we already have as well as any information we receive in the future. We will provide you with the revised notice by making it available to you upon request and by posting a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our practice's privacy officer. All complaints must be submitted in writing. We will neither penalize you nor retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to your Protected Health Information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

MINORS & PARENTS: Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Please note that you, not your insurance company, are responsible for full payment of my fees. **You should know that in some cases, the insurance companies may share clinical information with a national medical information databank.**

By signing this Agreement, you agree to the above terms. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You may request a copy of this document.

Print Name

Patient's Signature

Date