RESONANCE PSYCHIATRY LLC

1400 Hooper Ave, Ste 2
Toms River, NJ 08753
Effective Date: 1/7/2025

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION

At **Resonance Psychiatry LLC**, we understand that your **protected health information (PHI)** is personal. We are committed to safeguarding the privacy of your medical records and ensuring that your information is used appropriately.

This notice applies to all records of your care generated by **Resonance Psychiatry LLC**, including **psychiatric evaluations, medication management, and treatment notes**.

We are required by law to:

- Maintain the **privacy and security** of your protected health information (PHI).
- Provide you with this **Notice of Privacy Practices** explaining how we may use and share your PHI.
- Follow the **terms of this Notice** currently in effect.
- Notify you if a **breach of your PHI** occurs.

We may change the terms of this Notice at any time. **Updated versions will be available on our website, upon request, and in our office.**

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

1. For Treatment, Payment, or Healthcare Operations (Without Your Authorization)

Federal privacy laws allow healthcare providers to use and disclose PHI without written authorization **for treatment, payment, and healthcare operations**:

- **For Treatment:** We may use or disclose your PHI to provide, coordinate, or manage your treatment. This includes sharing information with other healthcare professionals involved in your care (e.g., primary care providers, specialists, therapists, pharmacists).

- **For Payment:** We may use and disclose your PHI to bill and collect payment for services provided. This may involve sharing PHI with your health insurance provider or third-party payers.

- **For Healthcare Operations:** We may use your PHI for internal quality improvement, staff training, compliance audits, and business administration.

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2. Other Uses & Disclosures Without Your Authorization

There are **limited situations** where we may disclose your PHI without prior consent:

- **Required by Law:** We must disclose PHI when required by federal, state, or local law.
- **Public Health & Safety:** Reporting suspected child abuse, elder abuse, or preventing a serious threat to public safety.
- **Health Oversight Activities:** Complying with audits, investigations, or licensing requirements.
- **Legal Proceedings:** If required by court order, subpoena, or legal mandate.
- **Law Enforcement Requests:** Assisting law enforcement when legally required.
- **Military & National Security:** If required for military missions, intelligence, or national security purposes.
- **Workers' Compensation:** To comply with workers' compensation laws.

III. USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

We will **not** use or disclose your PHI for the following purposes **without your written authorization**:

✔ **Psychotherapy Notes (If Applicable):** These require separate written permission for use.
✔ **Marketing Purposes:** We do not sell or share your PHI for marketing.
✔ **Sale of PHI:** We do not sell your health information.
✔ **Other Disclosures:** Any other uses outside of standard treatment, payment, and healthcare operations.

💡 **If you sign an authorization for any of these, you can revoke it at any time in writing.**

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Right to Access & Copies of Your Records

- You may request a **copy of your medical records** (electronic or paper).
- We will provide records within **30 days of receiving a written request** (fees may apply for copies).

2. Right to Request Confidential Communications

- You may request **alternative communication methods** (e.g., using a different mailing address or phone number).
- We will accommodate reasonable requests.

3. Right to Request Restrictions on Disclosures

- You may request **restrictions on how we use or share your PHI** for treatment, payment, or healthcare operations.
- We are **not required to agree** to a restriction request but will consider it.

4. Right to Restrict Disclosures to Insurance

- If you **pay in full out-of-pocket** for a service, you may request that we **do not disclose that service to your health plan**.
- We must comply unless legally required to share the information.

5. Right to Request Amendments to Your Records

- If you believe there is an error in your medical record, you may request a **correction in writing**.
- We may deny your request if we believe the record is accurate, but you will be informed in writing within **60 days**.

6. Right to an Accounting of Disclosures

- You may request a **list of times we have disclosed your PHI** for purposes other than treatment, payment, or healthcare operations.
- We will provide a report of disclosures made in the past **six years** at no cost (additional requests may incur fees).

7. Right to a Paper or Electronic Copy of This Notice

- You may request a **paper copy** of this Notice at any time, even if you received it electronically.

V. HOW TO FILE A PRIVACY COMPLAINT

If you believe your **privacy rights have been violated**, you can:

1. **File a Complaint with Resonance Psychiatry LLC**
    - Contact: **Jennifer Bowen, DNP, PMHNP-BC**
    - **Phone:** 908-430-0597
    - **Fax:** 617-993-0165
    - **Email:** [Insert Business Email]
    - **Mailing Address:** Resonance Psychiatry LLC, 1400 Hooper Ave, Ste 2, Toms River, NJ 08753

2. **File a Complaint with the U.S. Department of Health & Human Services (HHS)**
    - **Office for Civil Rights (OCR)**
    - **Website:** www.hhs.gov/ocr/privacy/hipaa/complaints
    - **Phone:** 1-800-368-1019
    - **Mailing Address:** U.S. Department of Health & Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201

🔹 **We will not retaliate against you for filing a complaint.**

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Under **HIPAA**, you have rights regarding your protected health information (PHI). By signing below, you acknowledge that you have received and understand this **Notice of Privacy Practices**:

- **I acknowledge that I have received and reviewed the Notice of Privacy Practices.**
- **I understand how my health information may be used and shared.**
- **I understand my rights regarding my health information.**