Intake:

Thank you for scheduling your appointment with The Psychiatry Group. We work with injured workers and help with diagnosis and treatment of psychiatric conditions to enable them to return to work safely and effectively.

We understand that your time is valuable. While this packet is lengthy, it will help your treatment team to understand your condition better and respond to queries from your treatment team members, Department of Labor and Industries and other authorized parties. This packet would require approximately 30 minutes of your time. If you do not understand a question, please ask your doctor on the day of your appointment. Please complete as much of this form as you can prior to the appointment.

This packet must be completed and returned before your appointment. Failure to do so may result in your appointment being rescheduled to the next available slot.

Please pay close attention to the policies including confidentiality. In certain situations, we are required to release medical information to third parties. If you have any questions, please ask us before your appointment. Your medical providers at the Psychiatry Group can answer some of your questions as well.

Your treatment team will include the doctor doing initial assessment and other psychiatrists, nurse practitioners and physician assistants. In many cases, your follow up care will be through a certified physician assistant or nurse practitioner. Our medical office staff will assist you with your questions and concerns. All of our treatment is provided remotely through a HIPAA compliant secure video system.

We look forward to working with you to help you achieve your goals.

Name

DOB

Claim Number

Date of Injury

Address

Phone number:

Check box: I agree to receive SMS messages and phone calls /voicemails from the medical office and staff.

Emergency Contact:

Name:

Phone Number:

Reason for the visit:

How has the injury affected your life:

Family history of psychiatric illness:

Education:

Previous employments:

Prior work injuries, reprimands and terminations:

Military History:

Legal History:

Substance use:

Alcohol:

Tobacco:

Cannabis:

Drugs:

Previous psychiatric treatment history:

Previous psychiatric diagnosis and treatment

Psychiatric Hospitalization

Suicide attempts

Traumatic experiences and abuse before or after the injury:

WHODAS 2.0
World Health Organization Disability Assessment Schedule 2.0
36-item version, self-administered

Patient name: ____________________
Claim number:___________ Date:________

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the past 30 days and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the last 30 days, how much difficulty did you have in:
Understanding and communicating

D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or can not do
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or can not do
D1.3	Analyzing and finding solutions to problems in dayto- day life?	None	Mild	Moderate	Severe	Extreme or can not do
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or can not do
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or can not do
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or can not do
Getting around						
D2.1	Standing for long periods, such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or can not do
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or can not do
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or can not do
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or can not do
D2.5	Walking a long distance, such as a kilometer (or equivalent)?	None	Mild	Moderate	Severe	Extreme or can not do
Self care						
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or can not do
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or can not do
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or can not do
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or can not do
Getting along with people						
D4.1	Dealing with people you do	None	Mild	Moderate	Severe	Extreme or

	not know?					**can not do**
D4.2	**Maintaining a friendship?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D4.3	**Getting along with people who are close to you?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D4.4	**Making new friends?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D4.5	**Sexual activities?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
Life activities-Household						
D5.1	**Taking care of your household responsibilities?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D5.2	**Doing most important household tasks well?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D5.3	**Getting all of the household work done that you needed to do?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D5.4	**Getting your household work done as quickly as needed?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
Life activities-School/Work						
If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5-D5.8, below. Otherwise, skip to D6.1.						
Because of your health condition, in the past 30 days, how much difficulty did you have in:						
D5.5	**Your day-to-day work/school?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D5.6	**Doing your most important work/school tasks well?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D5.7	**Getting all of the work done that you need to do?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D5.8	**Getting your work done as quickly as needed?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
Participation in society						
In the past 30 days:						
D6.1	**How much of a problem did you have in joining in community activities (for example, festivities,**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**

	religious, or other activities) in the same way as anyone else can?					
D6.2	**How much of a problem did you have because of barriers or hindrances around you?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D6.3	**How much of a problem did you have living with dignity because of the attitudes and actions of others?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D6.4	**How much time did you spend on your health condition or its consequences?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D6.5	**How much have you been emotionally affected by your health condition?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D6.6	**How much has your health been a drain on the financial resources of you or your family?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D6.7	**How much of a problem did your family have because of your health problems?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**
D6.8	**How much of a problem did you have in doing things by yourself for relaxation or pleasure?**	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or can not do**

Patient Health Questionnaire and General Anxiety Disorder
(PHQ-9 and GAD-7)

Date________________ Patient Name:____________________ Date of Birth: _______________

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score of each column				

Total Score (add your column scores): _______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the day**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Statement of Patient Financial Responsibility

Patient Name:

DOB:

The Practice appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to The Practice , for providing

services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to The Practice , the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature

Date

Guarantor Signature

(If guarantor is not the patient)

Date

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature

Date

Consent for Treatment and Authorization to Release Information

I hereby authorize The Practice, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.
I further authorize The Practice, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature

Date

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.
I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.
The Practice will notify you in writing, via certified mail, if you are discharged from care
I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature

Date

Self-Pay

I do not have health insurance and will be responsible for services rendered here at The Practice. I agree to pay The Practice, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature

Date

Motor Vehicle Insurance (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature

Date

Patient/Guarantor Signature

Tele-Medicine Informed Consent

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I understand that I have the right to inspect all information obtained and recorder in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at this time. My provider has explained the alternatives to my satisfaction.

I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

I understand that it is my duty to inform my provider of electronic interactions regarding my care that i may have with other healthcare providers.

I understand that i may expect the anticipated benefits from the use of telemedicine in my care. But that no results can be guaranteed or assured.

I understand, acknowledge and agree that the following must be strictly complied with if I receive direct access telemedicine services:

I shall be physically present in the state the provider is licensed;

ate the provider is licensed;

I do not use controlled substances;

I will be referred to the clinic for services if the provider determines I am unstable to receive

direct access telemedicine services;

I will not receive direct access telemedicine services if I am in crisis.

Initials:

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize

(name of provider) to use telemedicine in the course of my diagnosis and treatment.

Please initial after reading this page:

Signature of patient (or person authorized to sign for patient)_

Date:

If authorized signer, relationship to patient:

Witness:

Date:

I have been offered a copy of this consent form(patient’s initial)

HIPAA Notice of Privacy Practices

Disclaimer: Template Notice of Privacy Practices (45 C.F.R. § 164.520)

The information provided in this document does not constitute, and is no substitute for, legal or other professional advice. Users should consult their own legal or other professional advisors for individualized guidance regarding the application of the law to their particular situations, and in connection with other compliance-related concerns.

NOTICE OF PRIVACY PRACTICES

The Psychiatry Group LLC

Affiliate:

Effective Date:

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

1. How This Medical Practice May Use or Disclose Your Health Information.
2. When This Medical Practice May Not Use or Disclose Your Health Information.
3. Your Health Information Rights
    - Right to Request Special Privacy Protections.
    - Right to Request Confidential Communications.
    - Right to Inspect and Copy.
    - Right to Amend or Supplement.
    - Right to an Accounting of Disclosures
    - Right to a Paper or Electronic Copy of this Notice
4. Changes to this Notice of Privacy Practices.
5. Complaints

1. How This Medical Practice May Use or Disclose Your Health Information.

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our “business associates,” such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or

licensing activities, or their health care fraud and abuse detection and compliance efforts. should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments,

therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but
we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal

representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional

institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we
may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following:
1) use by the originator of the notes for your treatment,
2) for training our staff, students and other trainees,
3) to defend ourselves if you sue us or bring some other legal proceeding,
4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason,
5) in response to health oversight activities concerning your psychotherapist,
6) to avert a serious and imminent threat to health or safety, or
7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
Research. We may disclose your health information to researchers

conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

23. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health

information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or

incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. <u>Right to an Accounting of Disclosures.</u> You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be \reasonably likely to impede their activities.
6. <u>Right to a Paper or Electronic Copy of this Notice.</u> You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

- **Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

- **Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

OCRMail@hhs.gov

CONSENT TO RELEASE INFORMATION

____ ____/____/____

____

Patient Name (Please Print) **Date of Birth** **PSU ID# or SSN**

I authorize the Psychiatry Group PLLC, 3131 N Division St, Ste 201, Spokane, WA 99207, to Disclose/Receive (circle one) information contained in my record to/from (circle one):

Name

_______________________________________Organization/Agency:___________________________Fax:_________

_____

Address City State Zip______________

Purpose for disclosure: **□ Continuation of Care** **□ Payment of Claim** **□ Retroactive Withdrawal**
□ Other____

The information to be released is confined to the following:

Counseling/Psych. Services	**Health Services/Health Education**	**Student Disability Resources**
□ Attendance □ Diagnosis/Assessment □ Treatment Plans □ Psychosocial History □ Treatment Summary □ Other: ______________________	□ Health Hx/Immunization Records □ Physical Exam □ GYN. Exam □ Treatment Notes □ Lab Reports □ X-ray Reports □ Other:____________________________ □ AWARE/IMPACT Program Attendance and Compliance	□ Documentation of my Disability □ Accommodation Forms □ Other:_______________________

I understand that my record may contain information (including medications) related to alcohol/drug abuse and/or dependence, mental health, HIV and/or AIDS, and/or sexual assault. This information will be disclosed unless I specify that the information not be disclosed by initialing below: □ Alcohol/Drug Use □ Mental Health. □ HIV and/or AIDS. □ Sexual Assault

Specific information to be disclosed: □ copies □ verbal consultation.

I understand this release is valid _____ days or for one year from the date it was signed. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time except to the extent information has already been

released in reliance of this form. To revoke this authorization, I must do so in writing and present it to the Health and Wellness Center. The staff of the Health and Wellness Center can not be held legally liable for the interpretation or use by person/persons to whom they are released.

I have read and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose(s) stated above.

The treatment dates covered by this authorization are from_________________________ to
_________________________.

Patient Signature Date

Witness Signature Date

DISCLOSURE

This information has been disclosed to you from records protected by State and Federal Laws. You are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. Information related to HIV/AIDS, alcohol and other drugs, and mental health and abuse issues are protected by law and a general authorization for the release of medical or other information is not sufficient for this purpose.

A copy of the Authorization shall be deemed valid as original. This Authorization must be signed and dated.