

Potter Henderson, M.D.
Child, Adolescent & Adult Psychiatry
3772 Shore Drive, Suite 2
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Phone: 757.708.2149
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NOTICE OF PRIVACY PRACTICES

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

Uses and disclosures of health information – We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice for review. You can also request a copy of our notice at any time.

Individual rights – In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about your care. If you request copies, we may charge you for this service. You also have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints – If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact us directly to discuss the matter. You may also send a written complaint to the U.S. Department of Health and Human Services.

Our legal duty – We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the practices that are described in this notice. Your signature below affirms that you have read and understand our privacy practices.

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Patient Name: _____

Patient Signature: _____ **Date:** _____

Signature of parent or legal guardian: _____ **Date:** _____