

**PORTLAND INTEGRATIVE PSYCHIATRY**  
**NOTICE OF PRIVACY PRACTICES**

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.

Dear Patient,

Portland Integrative Psychiatry, LLC, an Oregon limited liability company (“we”, “us”, “our”, “Practice”), understands that our patient’s (“you”, “your”) privacy is important. This Notice of Privacy Practices (“Notice”) applies to Practice and each of our Business Associates, as applicable.

**Protected Health Information**

Protected health information (“PHI”) relates to information about you and your health, which could be used to identify you. Each time that you visit us, we create a medical record of your PHI and services that you receive.

**Our Obligations Regarding Your Protected Health Information**

We recognize that information about you and your health is confidential, and we are committed to protecting this information. This Notice applies to all your health records that we create.

We are required by law to preserve the privacy and security of your PHI. While there is no absolute guarantee of privacy, we are committed to protecting your privacy. We have established reasonable and appropriate measures to protect your PHI against unauthorized uses and disclosures.

Federal law mandates that we make this Notice available to you, and that we make a good faith effort to obtain a signed document acknowledging your receipt of this Notice. We are also required to follow the terms of this Notice. In the event that we are involved in a breach of your PHI, we will immediately notify you.

**Notice Effective Date and Potential Changes**

This Notice became effective on [REDACTED], 2019, and it applies to health records that we create for you. We reserve the right to change this Notice after the effective date. We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request.

**How We May Disclose Your Protected Health Information**

Oregon and federal law allow disclosures of your PHI. Some of these disclosures do not require your verbal or written permission. The following information describes how we may share your PHI. We may typically use or share your PHI in the following ways:

## **Treat you**

We can use your PHI and share it with other professionals who are treating you.

- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

## **Run our organization**

We can use and share your PHI to run our practice, improve your care, and contact you when necessary.

- Example: We use health information about you to manage your treatment and services.

## **Bill for your services**

We can use and share your PHI to bill and obtain payment from health plans or other entities.

- Example: We give information about you to your health insurance plan so it will pay for your services.

## **Help with public health and safety issues**

We can share your PHI for certain situations such as:

- Preventing disease;
- Helping with product recalls;
- Reporting adverse reactions to medications;
- Reporting suspected abuse, neglect, or domestic violence; and
- Preventing or reducing a serious threat to anyone's health or safety.

## **Perform research**

We can use or share your PHI for health research.

## **Comply with the law**

We will share your PHI if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

## **Respond to organ and tissue donation requests**

We can share your PHI with organ procurement organizations.

Work with a medical examiner or funeral director.

We can share your PHI with a coroner, medical examiner, or funeral director when an individual dies.

## **Address other government requests**

We can use or share your PHI:

- For workers' compensation claims;
- For law enforcement purposes or with a law enforcement official;
- With health oversight agencies for activities authorized by law; and
- For special government functions such as military, national security, and presidential protective services.

### **Respond to lawsuits and legal actions**

We can share your PHI in response to a court or administrative order, or in response to a subpoena.

### **How else can we use or share your PHI?**

We are allowed or required to share your PHI in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. We have not listed every use and disclosure in this Notice. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Use and Disclosure of Your PHI with Your Verbal Agreement**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care;
- Share information in a disaster relief situation; and
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

### **Use and Disclosure of Your PHI Requiring Your Written Permission**

If there are situations that have not been described above, we will obtain your written permission. In these cases, we never share your PHI unless you give us written permission:

- Marketing purposes;
- Sale of your information; and
- Most sharing of psychotherapy notes.

In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

If you provide us with written permission, you may change your mind at any time. Please let us know in

writing if you change your mind.

### **You're Rights Regarding Your PHI**

You have the following rights regarding your PHI that is created in our practice. This section explains some of your rights and our responsibilities to assist you.

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or receive an electronic or paper copy of your medical record and other PHI that we have about you. Ask us how to do this.
- We will provide a copy or a summary of your PHI, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct PHI about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone), or to send mail to a different address.
- We will say “yes” to all reasonable requests.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain PHI in connection with our services.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- Because you are privately paying for some medical or health services, you may ask us to refrain from sharing information related to those private pay services with your health insurance plan. We will respect that request unless we are legally obligated otherwise under applicable laws.

#### **Get a list of who we have shared information**

- You can ask for a list (accounting) of the times we have shared your PHI for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, health care operations, and certain other disclosures (such as any you asked us to make).
- We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### **Get a copy of this Notice**

- You can ask for a paper copy of this Notice at any time, even if you have agreed to receive this

Notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**Ask questions of file a complaint if you believe your rights are violated**

- If you have questions about this Notice or you believe that your rights are being violated, please contact us immediately:

**Practice Contact Information:**

Portland Integrative Psychiatry, LLC  
Attn: Tracy Filley  
14523 Westlake Drive, Suite 4  
Lake Oswego, OR 97035  
P: 503.765.5856

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints).

Please provide as much information as possible so that your concern or complaint can be thoroughly investigated. We will not retaliate against you for filing a complaint with us, or the Department of Health and Human Services.

Thank you,

**PRACTICE:**

**Portland Integrative Psychiatry, LLC**  
**an Oregon limited liability company**

By: \_\_\_\_\_  
Tracy Filley  
Sole Member/Managing Member

Date: \_\_\_\_\_

**PORTLAND INTEGRATIVE PSYCHIATRY  
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to undersigned patient (“Patient”):

Portland Integrative Psychiatry, LLC, an Oregon limited liability company (“Practice”), is required to provide Patient with a copy of Practice’s Notice of Privacy Practices (“Notice”), which states how Practice may use and/or disclose Patient’s health information.

Please sign this form to acknowledge receipt of the Notice.

Patient may refuse to sign this acknowledgment, if Patient wishes.

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I acknowledge that I have received a copy of Practice’s Notice of Privacy Practices.

Patient’s name (please print):

Signature:

Date:

**FOR OFFICE USE ONLY**

Practice made every effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices from Patient but it could not be obtained because:

- Patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgment.
- Practice was unable to communicate with Patient.
- Other: