

# GOODMAN PSYCHIATRIC GROUP, PLLC

## NOTICE OF PRIVACY PRACTICES (HIPAA)

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**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.**

**Effective Date:** January 1, 2026

**Our Commitment to Your Privacy** Goodman Psychiatric Group, PLLC is dedicated to maintaining the privacy of your protected health information (PHI). We are required by law to maintain the confidentiality of health information that identifies you.

**How We May Use and Disclose Health Information About You \* For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to other doctors, nurses, technicians, or other personnel who are involved in taking care of you. **\* For Payment:** We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party. **\* For Health Care Operations:** We may use and disclose medical information about you for our practice operations. These uses and disclosures are necessary to run the practice and make sure that all of our patients receive quality care.

**Situations Where We Are Required to Disclose Information \* Public Health Risks:** To prevent or control disease, injury, or disability. **\* Health Oversight Activities:** For audits, investigations, inspections, and licensure. **\* Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **\* Law Enforcement:** In response to a court order, subpoena, warrant, summons, or similar process. **\* Serious Threats to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Your Rights Regarding Health Information About You \* Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. **\* Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. **\* Right to an**

**Accounting of Disclosures:** You have the right to request a list of the disclosures we made of medical information about you. \* **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations.

**Changes to This Notice** We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

**Acknowledgement of Receipt** By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient Name (Printed): \_\_\_\_\_

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