

Notice of Privacy Practices
January 1, 2005

Alexander Z. Rivkin, M.D.
1033 Gayley Ave., Suite 104 Los Angeles, CA 90024
(310) 443-5273

To our patients, this describes how health information about you (as a patient) may be used and disclosed, and how you get access to your health information. This is required by the Privacy Regulations created with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We must provide you with the following information:

Use and disclose of your health information in special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities/health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact at home rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit request in writing to the practice manager whom will have up to 30 days to comply.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by, or for our practice. To request an amendment, your request must be made in writing and submitted to the practice manager whom will have 60 days to respond. You must provide us with a legitimate reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. During office hours, you may obtain a copy of this notice by contacting our front desk staff.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact our practice manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by law.

If you have any questions regarding this notice or our health information privacy policies, please contact the practice manager. I hereby acknowledge that I have been present with a copy of this notice of this Notice of Privacy Practices.

Print Patient Name _____ Today's Date _____

Signature of Patient (Parent/Guardian) _____