SUMMARY NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS A SUMMARY OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A complete explanation of the privacy practices of Omni Psychotherapy, LCSW, P.C. can be found in the attached Notice of Privacy Practices (the "Notice"). We are required by law to provide you with a copy of the Notice and comply with its terms. The attached Notice is meant to inform you more fully of the uses and disclosures of protected health information that we may make and your rights regarding your protected health information.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

- We will use and disclose your protected health information to provide you with medical treatment, to bill and receive payment for your medical treatment, for certain administrative purposes and to evaluate the quality of your care.
- We will make reasonable efforts to limit access to your protected health information to those persons who need access to carry out their duties.
- We may use or disclose your protected health information without your specific permission to enable third parties to perform a job for us or for other reasons permitted by law.

YOUR PRIVACY RIGHTS

- You may have the right to request certain restrictions or limitations on the protected health information we use or disclose.
- You may have the right to specify how you receive communications of protected health information.
- You may have the right to access and amend your protected health information for as long as it is maintained by Omni Psychotherapy, LCSW, P.C.
- You may have a right to request an accounting of disclosures of protected health information made by Omni Psychotherapy, LCSW, P.C.

QUESTIONS OR COMPLAINTS

If you have any questions or complaints about our privacy practices, please contact:
Hipaa Privacy Officer
180 South Broadway, Suite 405
White Plains, NY 10605

PLEASE SIGN THE ATTACHED CONSENT AND ACKNOWLEDGEMENT FORM TO ENABLE OMNI PSYCHOTHERAPY, LCSW, P.C. TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH OMNI PSYCHOTHERAPY, LCSW, P.C.'s NOTICE OF PRIVACY PRACTICES.

Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by Omni Psychotherapy, LCSW, P.C. to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. I understand that further information regarding how Omni Psychotherapy, LCSW, P.C. will use and disclose my information can be found in the Notice of Privacy Practices.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received Omni Psychotherapy's Notice of Privacy Practices currently in effect.

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

Unable to obtain written consent and acknowledgment because:

- ☐ Individual refused
- ☐ Emergency treatment situation
- ☐ Individual not able to sign due to incompetence or other medical reason
- ☐ Other: _____