

NOTICE OF PRIVACY PRACTICES

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

Privacy Officer – Rachel Berlin, M.D.; Phone Number 617-362-1101.

Rachel Berlin, M.D. may record, transmit, or maintain, either on paper or electronically, personal information about you, your medical history and your healthcare treatment as part of providing you with healthcare services or in connection with a health fair or other screening. This Notice of Privacy Practices (“Notice”) describes how we may use and disclose such information, our obligations regarding the use and disclosure of your medical information, and your rights with respect to the use and disclosure of your medical information. This Notice is required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

OVERVIEW

We are legally required to protect the privacy of information that identifies you or could be used to identify you, and relates to your past, present or future physical or mental health condition(s) or the provision of past, present, or future healthcare services (including payment for those services). This information is called “protected health information” or “PHI” for short.

We are legally required to follow the privacy practices that are described in this Notice. We reserve the right to change our privacy policies and the terms of this Notice at any time. Before any important policy change goes into effect, we will change this Notice.

We will post a copy of this Notice in all our registration areas for public viewing. You may also request a copy of this Notice at any time by contacting **Rachel Berlin, M.D. at 185 Devonshire St. Suite 902, Boston, MA 02110.**

USE AND DISCLOSURE OF YOUR PHI BY Rachel Berlin, M.D.

Rachel Berlin, M.D. may use or disclose your PHI to carry out its responsibilities as a healthcare provider. **Rachel Berlin, M.D.** may use or disclose your PHI without your written authorization for the following reasons:

- **Treatment.** **Rachel Berlin, M.D.** may disclose PHI to physicians, nurses, technicians, hospitals, medical students or other personnel who are involved with the administration of your care at **Rachel Berlin M.D.** or other locations.
- **Payment.** We may use and disclose PHI so that payment for the treatment and services you receive at **Rachel Berlin, M.D.** or from other entities, such as an ambulance company, may be billed to and collected from you, or an insurance company or third party. We may also need to disclose this information to insurance companies to establish insurance eligibility benefits for you.
- **Healthcare Operations.** “Healthcare operations” at **Rachel Berlin, M.D.** include activities related to improving quality of care, staff training, medical education, and business management.
- **Appointment Reminders, Information about Healthcare Related Benefits and Treatment Alternatives.** We may use and disclose medical information to contact you as a reminder that you have an appointment for a treatment or medical care at **Rachel Berlin, M.D.** or to inform you of treatment alternatives or other healthcare services or benefits that we offer.
- **As Required By Law.** We will disclose PHI when required to do so by federal or state law, including in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process. **Rachel Berlin, M.D.** may also disclose PHI to law enforcement personnel or similar persons to avoid a serious threat to the health or safety of a person or the public.

In addition, **Rachel Berlin, M.D.** may use your PHI without your written authorization under the following circumstances:

- Emergency situations when your authorization cannot be reasonably obtained, including for disaster relief purposes;
- To business associates (outside vendors or consultants that perform services on behalf of **Rachel Berlin, M.D.** and are contractually required to appropriately safeguard your information);
- To other healthcare facilities where **Rachel Berlin, M.D.** physicians and healthcare professionals have privileges or to physicians from other healthcare facilities who see patients of **Rachel Berlin, M.D.**;
- With your agreement, to a family member, relative, close personal friend, or any other person you identify;
- To facilitate organ or tissue donation if you are an organ donor;
- In connection with workers' compensation claims;
- To report abuse, neglect, or domestic violence as required by state or federal law;
- For public health and health oversight activities, such as preventing or controlling disease or investigations; or
- To coroners, medical examiners, or funeral directors as necessary to carry out their duties.

Certain actions, such as most uses of disclosures of psychotherapy notes, the use and disclosure of PHI for marketing purposes, and disclosures that constitute a sale of PHI, will be made only with your written permission (authorization). Other uses or disclosures of PHI that are not covered by this Notice or applicable laws also will be made only with your written permission.

Massachusetts provides special privacy protections for particularly sensitive conditions or illnesses such as HIV/AIDS, mental health, and substance abuse. **Rachel Berlin, M.D.** will disclose such information only in a manner that is consistent with these laws.

You may revoke your permission at any time by writing to **Rachel Berlin, M.D.** at the address below. Once you revoke your permission, we will stop using or disclosing such information for the reasons covered by your written authorization. However, we cannot take back any disclosures made with your permission. We will retain our records of the care provided to you as required by law.

YOUR RIGHTS REGARDING YOUR PHI

Although your medical information is the property of **Rachel Berlin, M.D.**, you have certain rights regarding your PHI, including the right to:

- **Inspect and Copy.** With certain exceptions, you have the right to inspect or receive a copy of your medical information or both. We may charge a fee for these services. We may deny your request in certain limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by **Rachel Berlin, M.D.** will review your request and our denial.
- **Request an Amendment.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend information that is kept by or for **Rachel Berlin, M.D.** We may deny your request if you ask us to amend information that (a) was not created by **Rachel Berlin, M.D.**; (b) is not part of the medical information kept by or for **Rachel Berlin, M.D.**; (c) is not medical information you are permitted to inspect or copy; or (d) is accurate and complete in the record.
- **Request an Accounting of Disclosures.** You may request a list of the disclosures we have made of PHI that were for purposes other than treatment, payment, healthcare operations and certain other purposes, or disclosures made with your written

authorization within the last six (6) years. You may be charged a fee in connection with this request.

- **Restrict or Limit Use or Disclosure.** You may ask us to restrict or limit the use or disclosure of your PHI, including the disclosure of information to someone who is involved in your care or the payment for your care, like a family member or friend. Your request must state: (1) what information you want to limit; (2) whether you want to limit **Rachel Berlin, M.D.**'s use, disclosure or both; and (3) to whom the limits apply, for example, disclosures to your spouse. We are not required to agree to your request, unless it relates to an item or service you paid for in full and out of pocket. In this case, you may request that we not share health information pertaining only to that product or service with your health plan for the purposes of carrying out payment or healthcare operations and we will comply with your request unless the information is needed to provide you emergency treatment or except as required by law.

- **Confidential Communications.** Generally, we will use the address, telephone number and, in some cases, the email address you give us to contact you. You may ask us to communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Notification in the Event of a Breach.** Consistent with federal and state laws, we will notify you in the event unsecured PHI is used or disclosed by an unauthorized individual. All requests must be submitted in writing to the address below. Your request must be specific and be signed by you or an authorized representative.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by writing to the address below or by calling the **Rachel Berlin, M.D.** compliance hotline at **617-362-1101**. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. or through the regional office at J.F.K. Federal Building – Room 1874, Boston, MA 02203. The complaint must be filed within 180 days of the alleged violation. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have questions, would like to submit a written request, or need further assistance regarding this policy, please contact **Rachel Berlin, M.D.** at:

185 Devonshire St. Suite 902
Boston, MA 02110
(617) 362-1101

EFFECTIVE DATE: This Notice of Privacy Practices is effective **08/01/2020**

By signing, I acknowledge that I have received a copy of Rachel Berlin, M.D.'s Notice of Privacy Practices.