Lily Health and Wellness Center

Phone: 240-425-4487
Fax: 240-425-4255
Email: admin@lilyhealthmd.com

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your health information is important to us.

Our Legal Duty

Lily Health and Wellness Center Telepsychiatry is required by federal and state law to maintain the privacy and security of your protected health information (PHI). We are also required to provide you with this Notice describing our legal duties and privacy practices.

This Notice becomes effective on ___ and will remain in effect until it is replaced. We reserve the right to change our privacy practices and the terms of this Notice at any time, as permitted by law. Any revised Notice will apply to all PHI we maintain, including information created or received prior to the change. Updated Notices will be made available upon request.

You may request a copy of this Notice at any time by contacting us using the information listed at the end of this document.

Uses and Disclosures of Health Information

We may use or disclose your health information for **treatment, payment, and health care operations**, as described below:

Treatment

We may use or disclose your health information to physicians, therapists, or other health care professionals involved in your care.

Payment

We may use and disclose your health information to obtain payment for services provided to you.

Health Care Operations

We may use or disclose your health information for operational purposes, including quality improvement, staff training, credentialing, licensing, accreditation, and business administration.

Other Permitted Uses and Disclosures

- **Authorization:** You may provide written authorization allowing us to use or disclose your health information for purposes not otherwise permitted. You may revoke such authorization in writing at any time.
- **Family and Friends:** With your permission, we may disclose relevant health information to family members, friends, or others involved in your care or payment for your care.
- **Persons Involved in Care:** In emergency or incapacity situations, we may disclose limited information based on professional judgment if it is in your best interest.
- **Marketing:** We will not use your health information for marketing purposes without your written authorization.
- **Required by Law:** We may disclose your health information when required by law, including for public health activities, abuse or neglect reporting, or to prevent serious threats to health or safety.
- **National Security and Law Enforcement:** We may disclose information for military, national security, law enforcement, correctional institution, or lawful government functions as permitted by law.
- **Appointment Reminders:** We may contact you with appointment reminders via phone, voicemail, text, or mail.

Patient Rights

You have the right to:

- **Access:** Inspect or obtain copies of your health information in paper or electronic format.
- **Restrictions:** Request limits on certain uses or disclosures of your information (we are not required to agree in all cases).
- **Confidential Communications:** Request communication by alternative means or locations.
- **Amendment:** Request correction of your health information if you believe it is inaccurate or incomplete.
- **Electronic or Paper Notice:** Receive a paper copy of this Notice at any time, even if you agreed to receive it electronically.

Reasonable, cost-based fees may apply for copies or alternative formats, consistent with HIPAA regulations.

Questions and Complaints

If you have questions about this Notice or believe your privacy rights have been violated, you may contact us using the information below:

Privacy Officer: _____
Phone: ___
Fax: ____
Email: **___**
Address: **____**

You may also file a complaint with the **U.S. Department of Health and Human Services, Office for Civil Rights**. We will not retaliate against you for filing a complaint.

Acknowledgment of Receipt

Patient Name (Last, First): _____

Date of Birth: _____

Patient Signature: _____
Date: ____