Mark R. Dell, Psy.D, L.L.C.
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(609) 439-6526

NOTICE OF PRIVACY PRACTICES

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

Effective Date: _____

I. MY COMMITMENT

I am required by law to maintain the privacy of your Protected Health Information (PHI), provide you this Notice of my legal duties and privacy practices, and follow the terms of the Notice currently in effect.

II. USES AND DISCLOSURES WITHOUT YOUR AUTHORIZATION

Treatment, Payment, and Health Care Operations. I may use your PHI to provide, coordinate, or manage your care, to obtain payment for services, and to conduct quality and administrative functions of this practice.

Required or Permitted by Law. I may disclose PHI without your authorization in the following circumstances:

1. When there is a serious and imminent risk of harm to you or an identifiable other person, disclosure may be made to prevent that harm.
2. When I have reasonable cause to believe a child, elder, or dependent adult has been abused or neglected, I am required to report to the appropriate authority.
3. When required by court order, subpoena, or other lawful process.
4. For public health and safety activities, health oversight activities, or as otherwise required by law.

With these exceptions, information shared in our work together is confidential.

III. USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

All other uses and disclosures of your PHI will be made only with your written authorization. You may revoke that authorization in writing at any time, except to the extent I have already acted in reliance on it. Psychotherapy notes, marketing communications, and any sale of PHI require your specific written authorization.

IV. YOUR RIGHTS

Access. You may inspect and obtain a copy of your record, subject to limited legal exceptions.

Amendment. You may request an amendment to your record if you believe it is inaccurate or incomplete.

Accounting of Disclosures. You may request a list of certain disclosures I have made of your PHI.

Restrictions. You may request restrictions on how I use or disclose your PHI. I am not required to agree to all requests.

Confidential Communications. You may request that I contact you by a particular method or at a particular location.

Paper Copy. You may obtain a paper copy of this Notice at any time.

Complaint. You may file a complaint with me or with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Requests concerning your rights should be submitted in writing to this office.

V. RECORD RETENTION

Clinical records are retained in accordance with New Jersey law for a minimum of seven years from the date of last entry, or, for a patient who was a minor, until the patient reaches age 25, whichever is longer.

VI. CHANGES TO THIS NOTICE

I reserve the right to change this Notice and to make the revised Notice effective for PHI I already hold as well as information I receive in the future. A current copy will be available in this office upon request.

VII. ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient / Client Signature: _____ Date: _____

Printed Name: _____

Provider: Mark R. Dell, Psy.D. NJ License #: 35SI00480700