



Advanced Mental Health Center

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HIPPA NOITICE OF PRIVACY PRACTICES

- I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**
- II. IT IS MY LEGAL DUTY TO SAFEGAURD YOUR PROTECTED HEALTH INFORMATION (PHI).**

By law we are required to insure that your PHI is kept private. The PHI constitutes information created or noted by us that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. We are required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when we share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exception, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this Notice.

Please note that we reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with our clinic. Before we make any important changes to our policies, we will immediately change this Notice and post a new copy of it in our office and on our website. You may also request a copy of this Notice from clinical staff, or you can view a copy of it in our office or on our website.

By signing this form, you acknowledge receipt of our Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice of Privacy Practices. If you have any questions about our Notice of Privacy Practices, please ask **Dr. Farzaneh Ehsan**.

Acknowledgement of Receipt: I acknowledge receipt of the Notice of Privacy Practices as provided by Farzaneh Ehsan Psy,D and or her clinical staff.

Signature: _____ Date: _____

Patient, Parent or Legal Guardian:

Patient's name: _____