Atroypen Group, Inc.

Participant's Name:

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2019

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.

If you have any questions about this notice, please contact the Compliance Officer.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgement of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledge. If you decline to provide a signed acknowledge, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

WHO WILL FOLLOW THIS NOTICE

This notice describes agency practices regarding your protected health information. For this notice, the agency includes the following:

- Any Employee of Atroypen Group, Inc.
- Health care providers contracted with Atroypen Group, Inc. who transmits any health information in an electronic format for certain transactions.
- Health care clearing houses contracted with Atroypen Group, Inc. that processes or facilitates the processing of information received from us.
- Business Associates

OUR DUTIES TO YOU REGARDING PROTECTED HELTH INFORMATION

"Protected health information" is individually identifiable health information. This information includes demographics, for example, age, address, e-mail address, and relates to your past, present, or future physical or mental health or condition and related health care services. Atroypen Group, Inc. is required by law to do the following:

- Make sure that your protected health information is kept private.
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in the notice to you.
- Atroypen Group, Inc. reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Following are examples of permitted uses and disclosures of you protected health information. These examples are not exhaustive.

Required Uses and Disclosures

By law, we must disclose your health information to you unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose health information to the Department of Children and Families for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example; we may use your protected health information to coordinate a home visit with you. If you are a minor receiving treatment in your school, your teacher and/or school counselor is involved in your treatment and has "minimum necessary" access to your protected health information. If you are participating in family therapy, family members may share their confidences as part of your treatment.

Payment

Your protect health information will be used, as needed, to obtain payment for your health care services. This may include certain activities Atroypen Group, Inc. might undertake before it approves services request by you or other agencies such as determining eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, verifying insurance eligibility might be required prior to providing services.

Health Care Operations

We may use or disclose, as needed, your protected health information to support the daily activities related to health care. These activities include, but are not limited to, quality assessment activities, investigations, oversight or staff performance reviews, licensing, communications about product or service and conducting or arranging for other health care related activities. We may also use your health information to arrange for a referral or clinical consultation with your school.

For example, we will share your protected health information with third-party "business associates" who performs various activities (for example, billing services) for Atroypen Group Inc (AGI). The business associates will also be required to protect your health information.

We may disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health care benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about our agency and the services we offer. We may also send you information about products or services that we believe might benefit you.

We may use or disclose your protected health information, as necessary, to contact you with information during fund raising activities. For example, we may send you a letter requesting you call a certain person or office asking them to support our agency.

Required by Law

We may use or disclosure your protected health information if law enforcement requires the use of disclosure.

Public Health

We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. The disclosure may be necessary to do the following:

- Report child abuse or neglect
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs, and civil rights law.

Legal Proceedings

We may disclose protected health information during judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and certain conditions in response to a subpoena, discovery request, or other lawful process.

Research

We may disclose your protected health information to a researcher when authorized by law, for example, if their research had been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity

Under applicable Federal and state laws, we may disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Worker's Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar legally established programs.

Parental Access

If you are a minor, we may disclose your protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the state law and make disclosure following such laws.

USES AND DISCLOSURES OF HEALTH INFORMATION REQUIRING YOUR PERMISSION

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following are some examples in which your agreement or objection is required.

Individuals Involved in Your Health Care

Unless you object, we may disclose to a member of your family, a relative, close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You may exercise the following rights by submitting a written request to the Atroypen Group, Inc., Compliance Officer. Depending on your request, you may also have rights under the Privacy Act of 1974. Our Officer can guide you in pursuing these options. Please be aware the Atroypen Group, Inc. might deny your request: however, you may seek a review of the denial.

Right to Inspect and Copy

You may inspect and obtain a copy of your health information that is contained in a "designed record set" for as long as we maintain the protected health information. A designed record set contains medical and billing records and any other record Atroypen Group, Inc. uses for making decisions about you.

This right does not include inspection and copying of the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

Right to Request Restrictions

You may ask us not to use or disclose any part of your protected health information for treatment, payment, or health care operations. Your request must be made in writing to the agency's Compliance Officer. In your request, you must tell us (1) what information you want restricted; (2) whether you want to restrict our use, disclose, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date.

Right to Request Confidential Communications

You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment

If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information for as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosures

You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. This disclosure must have been made after April 14, 2003, and no more than 6 years from the date of request. This right excludes disclosures made to you, to your family members or friends involved in your care, or for notification. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this notice.

Right to Obtain a Copy of This Notice

You may obtain a copy of this notice from us by visiting our office or requesting by phone, e-mail or fax. See contact information in this notice.

FEDERAL PRIVACY LAWS

This Agency's Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the freedom of Information Act, the Privacy Act and the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act. These laws have not been superseded and have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

COMPLAINTS

If you believe these privacy rights have been violated, you may file a written complaint with our Compliance Officer. If you wish, our privacy officer will give you a form that you can use to submit a complaint.

You can also submit a complaint to the United States Department of Health and Human Services. Send your complaints to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
HOTLINE: 1800-368-1019.

No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION

You may contact the Atroypen Group, Inc.'s Compliance Officer for further information about the complaint process, or for further explanation of this document. The Atroypen Group, Inc., Officer may be contacted at:, 4302 W Broward Blvd, Plantation, Suite 101, FL 33317 or by phone at (954) 825-5368. You may email question to: lbryant.atroypen@gmail.com . For more information regarding your privacy visit the Health and Human Services website at http://www.myflorida.com/myflorida/sto/hipaa/index.html.

This notice is effective in its entirety as of April 14, 2019.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

Atroypen Group, Inc. *is required by law to maintain the privacy of "protected health information (PHI) about you the person we serve. This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Pathways Behavioral Group can use PHI for treatment, payment, health care operation and if otherwise, as required. No other disclosures of PHI will be made without your written Authorization. You have other legal rights, which include, the right to request confidential communications, to request restrictions on use and disclosure, to revoke a Consent or Authorization, to review and copy the record, to amend the record, to an accounting, and a paper copy of the notices of Privacy Practices.*

Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledge. If you decline to provide a signed acknowledge, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I, _____, parent or legal guardian of _____, indicate by my signature on this form that I have received a copy of this Notice of Privacy Practices.

Signature: _____ Date: _____

OR

I, _____, indicate by my signature on this form that I have received a copy of this Notice of Privacy Practices.

Signature: _____ Date: _____

OR

Patient Served declined to sign acknowledgment (please initial) _____ Date: _____

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