

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

Is accurate and complete;

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the medical information kept by or for the facility; or

Is not part of the information which you would be permitted to inspect and copy;

#### **C. RIGHT TO AN ACCOUNTING OF DISCLOSURES**

You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer for Central Kentucky Psychiatry. Your request must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**D. RIGHT TO REQUEST RESTRICTIONS** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, then we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the liaison to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

#### **E. RIGHT TO REQUEST CONFIDENTIAL**

**COMMUNICATIONS** You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the liaison to the of the privacy officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**F. RIGHT TO A PAPER COPY OF THIS NOTICE** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Even if you agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

#### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facilities. The notice will contain the effective date on the last page of the notice.

#### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the Privacy Officer for Central Kentucky Psychiatry, PLLC at (859) 238-0018.

**You will not be penalized for filing a complaint.**

#### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will only be made with your written permission. If you provide us permission to use or disclose medical information about you, then you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

**If you have any questions about this notice, please contact the Privacy Officer for Central Kentucky Psychiatry, PLLC at (859) 238- 0018.**

**Effective Date of Notice: June 2, 2008**