





# JEFFREY S. GANDIN, M.D.

450 North Bedford Drive, Suite 307  
Beverly Hills, California 90210  
tel 310.497.8900  
fax 310.551.4131  
jgandin@ucla.edu

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## AUTHORIZATION TO RELEASE OUTPATIENT PSYCHOTHERAPY, PSYCHIATRIC, MEDICAL, BILLING AND/OR ALCOHOL-DRUG ABUSE RECORDS AND INFORMATION

I hereby authorize **JEFFREY GANDIN, M.D. 450 N. BEDFORD DR., STE. 307, B.H., CA 90210 (or the covering physician)** to release the information which is contained in any outpatient psychotherapy, psychiatric, medical, billing, alcohol and/or drug abuse records which he may have regarding **ME**, (FULL NAME) \_\_\_\_\_, including any and all information gained in interviewing **ME** and examining **ME** including, but not limited to, any outpatient treatment with a psychotherapist, under the conditions listed below:

1. The information and records which may be released are limited to all medical records or other information obtained by **JEFFREY GANDIN, M.D. (or the covering physician)** through interviews with **ME** or inquiries concerning or obtained from other persons, and will include all outpatient psychotherapy, psychiatric, medical, billing, alcohol and/or drug abuse records which are in the possession or control of **JEFFREY GANDIN, M.D. (or the covering physician)**.
2. The purpose of such disclosure is for use in connection with: **Coordination of care, payment, and/or support** and (if more) \_\_\_\_\_ The information and records released pursuant to this consent will not be used for any other purpose.
3. The persons or entities authorized to receive the information and records covered by this consent are (please include relationship/position, name, address, FAX, Tel #):

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4. I understand that there is a risk that the person receiving information or documents pursuant to this authorization may re-disclose the information and documents in a manner which will no longer provide protection for the information and documents.
  5. I understand that I may refuse to sign this authorization.
  6. I understand that I may receive a copy of this authorization.
  7. I understand that this release automatically expires within 90 days unless I authorize the following expiration by checking the associated box:

- I would like this authorization to expire only once my care at Dr. Gandin's office has terminated.  
 I would like this authorization to expire on the following date: \_\_\_\_\_

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Patient's/Rep Signature

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Patient's/Rep Name (printed)

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Date

# JEFFREY S. GANDIN, M.D.

DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

TEL 310.497.8900

• 450 North Bedford Drive, Suite 307 •

FAX 310.551.4131

Beverly Hills, California 90210

www.drgandin.com

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## TREATMENT CONTRACT & UNDERSTANDING OF OFFICE POLICIES

The following are DR. JEFFREY GANDIN's office policies. Please read them carefully:

► **PATIENT PAYMENT OBLIGATIONS.** All outpatient visits must be paid for at the time of visit. You will be provided with a receipt to submit to your insurance company. Jeffrey Gandin, M.D. cannot accept responsibility for negotiating claims with insurance companies or other persons. You are responsible for payment of your medical care regardless of the status of your claim. Any other financial arrangement must be made with Dr. Gandin prior to service.

- **MISSED OR CANCELED APPOINTMENTS WITH LESS THAN 24 BUSINESS HOURS NOTICE.** Should you need to cancel a session, please do so at least 24 hours in advance. Otherwise, the time you have booked will not be scheduled for anyone else, and you will automatically be charged at your regular rate for the canceled session.
- **RETURNED CHECKS.** You will automatically be charged for the amount of your returned check plus a \$20 fee.
- **OUTSTANDING BILLS.** Outstanding bills will be re-billed monthly. If payment is not received after two successive billings, your account may be sent to a collection service.

► **ROUTINE CLINICAL QUESTIONS BETWEEN VISITS.** For routine clinical concerns and questions, please leave a message on Dr. Gandin's voice-mail at 310.497.8900. He will call back as soon as possible, usually by the next business day. Note that Dr. Gandin's office does not check his messages on weekends or holidays, or after 4pm on regular weekdays. For emergencies that cannot wait until Dr. Gandin's office checks his messages, please see "Urgent/Emergent Situations." Non-urgent calls of an administrative nature may be returned by an administrative assistant who will maintain Dr. Gandin's confidentiality procedures.

### ► URGENT/EMERGENT SITUATIONS

Call Dr. Gandin's office phone number 310.497.8900 and listen to the complete outgoing message for instructions on how to page him or the covering physician. In the rare event that you do not receive a callback within 20 minutes, please assume this is due to technical difficulties with the paging system and you may page again. If your situation is so emergent (e.g., life-threatening) that you cannot wait for Dr. Gandin or the covering physician to return your page, then call **911**.

► **PHARMACY REFILLS.** Please call your pharmacy and have them contact Dr. Gandin's office at least **48 business** hours in advance.

► **VACATIONS.** Dr. Gandin's outgoing message on 310.497.8900 will notify callers that he is out of the office and will leave instructions on how to contact him or the covering physician.

I agree in the event of non-payment to bear all the costs of collection, court costs and legal fees as are required.

I hereby acknowledge full responsibility for the payment of services rendered by Jeffrey Gandin, M.D.

I have read and understood and I agree with the foregoing, and consent to this evaluation and/or treatment.

A facsimile or photocopy of this signature is as valid as the original.

\_\_\_\_\_  
Patient's name (printed)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

# JEFFREY S. GANDIN, M.D.

## HIPAA NOTICE OF PRIVACY PRACTICES

**Effective Date: August 1, 2007**

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care. This Notice describes how physical & mental health information about you may be used and disclosed, your rights regarding this information, and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact: **THE OFFICE MANAGER at The Office of Jeffrey S. Gandin, M.D., 450 North Bedford Drive, Suite 307, Beverly Hills, California, 90210; 310.497.8900.**

This Notice describes the privacy practices at Dr. Jeffrey Gandin's office.

### **We are required by law to:**

- Maintain the privacy of protected health information as required by law
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of the Notice currently in effect.

### **How we may use and disclose your health information:**

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to THE OFFICE MANAGER.

**Treatment.** We may use and disclose your physical & mental health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your physical & mental health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. We may also share physical & mental health and substance abuse information about you with other healthcare providers, agencies or facilities who are treating you for a medical or psychological condition, in order to provide or coordinate the different things you need, such as prescriptions or types of therapy. We also may disclose mental health information about you to people who may be involved in your continuing mental health or medical care after you leave our practice, such as other health care providers, transport companies, community agencies and family members.

**Payment.** We may use and disclose your physical & mental health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

**Health Care Operations.** We may use and disclose your physical & mental health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

**Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services.** We may use and disclose your physical & mental health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share your physical & mental health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition. Any such disclosure will be limited to information directly related to the person's involvement in your care. If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

**Disaster Relief.** We may disclose physical & mental health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts. If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated, we will use our professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

**Research.** We may use and disclose your physical & mental health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your physical & mental health information.

**As Required by Law.** We will disclose your physical & mental health information when required to do so by international, federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose your physical & mental health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can help prevent or reduce the threat.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Organ and Tissue Donation. If you are an organ donor, we may release mental health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your physical & mental health information as required by military command authorities. If you are a member of a foreign military we may release your physical & mental health information to the foreign military command authority.

Workers Compensation. We may release your physical & mental health and substance abuse information for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Disclosures We may disclose physical & mental health information about you for public health purposes. These purposes generally include the following: (1) preventing or controlling disease (such as cancer and tuberculosis), injury or disability; (2) reporting vital events such as births and deaths; (3) reporting child abuse or neglect; (4) reporting adverse events or surveillance related to food, medications or defects or (5) reporting problems with products; (6) notifying persons of recalls, repairs or replacements of products they may be using; (6) notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; (7) notifying the appropriate government authority if we believe a patient has been the victim of abuse or neglect and make this disclosure as authorized or required by law; (8) notifying the coroner of a patient's death; (9) notifying emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal law; (10) notifying multidisciplinary personnel teams relevant to the prevention, identification, management, or treatment of an abused child and the child's parents or an abused elder or dependent adult.

Health Oversight Activities. We may disclose your physical & mental health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. We may release your physical & mental health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your physical & mental health information in response to a court or administrative order. We may disclose your physical & mental health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release as appropriate your physical or mental health information to law enforcement: (1) pursuant to a subpoena by law enforcement; (2) as needed for the protection of others; or (3) if there is a court order, subpoena, or other legal process for release of the information. Information may also be released to (1) law enforcement without their request in order to protect others whom you threaten to injure and to (2) persons who are in danger from a threat you have made.

Department of Justice. We may disclose limited information to the California Department of Justice for movement and identification purposes about certain criminal patients, or regarding persons who may not purchase, possess or control a firearm or deadly weapon.

Protection of Elective Constitutional Officers. We may disclose mental health information about you to government law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.

National Security and Intelligence Activities. We may disclose your physical & mental health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

## **YOUR RIGHTS REGARDING YOUR PHYSICAL & MENTAL HEALTH INFORMATION**

Right to Inspect and Copy. You have the right to inspect and or receive a copy of your physical & mental health information and billing records. In order to do so, you need to send a written request to THE OFFICE MANAGER. If you request a copy of the information, there is a fee for these services. We may deny your request to inspect and/or to receive a copy in certain very limited circumstances.

Right to Amend. You have the right to request an amendment to your records by written request to THE OFFICE MANAGER.

Right to an Accounting of Disclosures. You have a right to an accounting of certain disclosures by written request to THE OFFICE MANAGER.

Right to Request Restrictions. You have the right to request restriction or limitation on your physical & mental health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to THE OFFICE MANAGER. We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to THE OFFICE MANAGER. We will accommodate reasonable requests.

QUESTIONS OR COMPLAINTS. If you have any questions about this Notice, please contact THE OFFICE MANAGER. If you believe your privacy rights have been violated, you may file a complaint with THE OFFICE MANAGER. To file a complaint with the Secretary of the Department of Health and Human Services contact the: Department of Health and Human Services, Office of Civil Rights, South United Nations Plaza, Room 322, San Francisco, CA 94102 (PHONE) (415) 437-8310, (FAX) (415) 437-8329, (TDD) (415) 437-8311. You will not be penalized for filing a complaint.

OTHER USES OF YOUR HEALTH INFORMATION. Other uses and disclosures of physical & mental health information not covered by this Notice will be made only with your written permission. If you provide us permission to disclose such information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer disclose such information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

**CHANGES TO THIS NOTICE**

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to THE OFFICE MANAGER:

OFFICE MANAGER  
Jeffrey S. Gandin, M.D.  
450 North Bedford Drive, Suite 307  
Beverly Hills, California 90210  
310.497.8900

----- COMPLETE THE SHORT FORM BELOW, CUT HERE AND SEND TO DR GANDIN BY MAIL, EMAIL OR FAX-----

**JEFFREY S. GANDIN, M.D.**  
**450 North Bedford Drive, Suite 307**  
**Beverly Hills, California 90210**  
**fax: 310.551.4131**  
**email: jgandin@ucla.edu**

**Patient Acknowledgment of Receipt of  
HIPAA Notice of Privacy Practices**

**Patient Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

**Maiden/other name used (if applicable):** \_\_\_\_\_

**I acknowledge that I have received a copy of the Notice of Privacy Practices of  
JEFFREY S. GANDIN, M.D. effective August 1, 2007.**

**A photocopy or facsimile of this signature is as valid as the original.**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_