Nithya Ramanathan, M.D.

Board Certified Child and Adolescent Psychiatrist
Board Certified Adult Psychiatrist
5190 Blazer Pkwy
Dublin OH 43017
P: (614) 787-2714
F: (614) 389-3041
E: drr@dublinpsychiatricservices.com
www.dublinpsychiatricservices.com

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Under HIPAA, I understand that my personal information may be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly
- Obtain payment from third-party payers for my healthcare services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of Dublin Psychiatric Services LLC's Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that Dublin Psychiatric Services LLC has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I further understand that Dublin Psychiatric Services LLC is not required to accept my requested restrictions, but if they are accepted then I understand that Dublin Psychiatric Services LLC will honor my request unless it is an emergency.

I further understand that I have the right to not sign this acknowledgement in order to receive treatment at Dublin Psychiatric Services LLC.

Authorization to Communicate Protected Health Information - Check all that apply:
Dublin Psychiatric Services LLC may leave a detailed message on voicemail at my home #: (_____) __________________
Dublin Psychiatric Services LLC may leave a detailed message on voicemail at my cell #: (_____) ____________________
Dublin Psychiatric Services LLC may speak with another person (spouse, family member) about my medical condition **including / excluding** information related to mental/behavioral health, substance abuse, sexually transmitted disease, HIV status and reproductive medicine:

Name/Relation: __________________________________ Phone #: (_____) ___________________

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify Dublin Psychiatric Services LLC should I change one or more of the telephone numbers listed above.

_________________________ /____________ _________________________ / _______________
Signature / Today's Date Patient Name / Date of Birth

_______________________________________ ____

Representative Name /Relation to Patient