Notice of Privacy Practices

The Effective Date of this Notice is 9/27/2026.

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (PHI) is information that can be used to identify you as an individual. If your PHI is de-identified in accordance with HIPAA standards, it is no longer PHI. By law, I must:
(1) protect the privacy of your PHI;
(2) describe to you how your PHI will be used;
(3) tell you about your rights;
(4) tell you about my privacy practices;
(5) notify you if there is a breach of your unsecured PHI; and
(6) notify you if there is a change to my Privacy Practices.

Treatment:

I will share your PHI for you to receive medical treatment. This includes sharing it with other doctors, nurses, medical offices, imaging centers, hospitals, emergency departments, pharmacies, laboratories, home health companies, and providers of medical devices.

EXAMPLE #1: Sending your lab results and my office notes to a physician specialist whom I have referred you to for evaluation and treatment.

Payment:

I will disclose your PHI to receive payment from your insurance company.

EXAMPLE #1: Submitting my note from an office visit to your insurance.

Healthcare Operations:

I will share your PHI as necessary during standard healthcare operations. I will NOT sell your information or use it for marketing without your written consent.

INITIAL HERE: _____

EXAMPLE #1: quality of care reporting to Medicare;
EXAMPLE #2: calling you by your name while you are at my office.

Use of Electronic Health Records:

I maintain your health records in within an electronic health record operated by Elation Health. It has all the appropriate administrative, technical, and physical safeguards to protect your information.

Health Information Exchange:

Within my electronic health record I utilize a secure, electronic, health information exchange called “Carequality.” It allows me to access some of your records that are kept by other doctors and hospital systems. You can learn more at carequality.org. The alternative to a system such as this is to fax your records back and forth between physician offices. This carries the risk that information could be accidentally faxed to the wrong location. If you initial below "Do Not Use," then I will not obtain or share your records using Carequality.

_____ DO NOT USE

Elation Note Assist:

I use an AI software tool called “Elation Note Assist” within my electronic health record to make it easier to write my medical notes. It helps me spend more time focused on you and your story and less time on the computer. It also helps me to make sure I capture all the relevant details accurately. This tool listens to our conversation and convert it into a written summary in the visit note within the electronic health record. After the visit, I will review and edit for accuracy. The audio is permanently deleted as soon as the written summary is generated. A written transcript of the conversation is available to me for 14 days after which it is permanently deleted. Your medical information will stay private and only shared with those you allow. If you initial below "Do Not Use," then I will not use this tool during your visits and I will take notes on my computer instead.

_____ DO NOT USE

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As Required by Law:

In the following situations, I will disclose your PHI to the appropriate authorities under California law without your consent:

[1] EXPRESSION OF HOMICIDAL OR SUICIDAL INTENT. If you tell me that you intend to hurt yourself or another person, I am required by law to disclose that information to prevent or lessen that threat;

[2] PUBLIC HEALTH REPORTING: I am required by law to reports certain diseases and conditions to the Ventura County Health Department. This includes: (A) all sexually transmitted infections, (B) tuberculosis, (C) births and deaths, (D) communicable diseases. A complete list can be found on the Ventura County of Public Health website: https://hca.venturacounty.gov/public-health/disease-reporting-forms/;

[3] LAPSES OF CONSCIOUSNESS AND DEMENTIA: I am required by law to report lapses of consciousness (seizures, fainting) to the CA DMV.

[4] ELDER/DEPENDENT ABUSE AND NEGLECT: The abuse can take many forms including physical, sexual, financial, abandonment, isolation, and deprivation of goods and services that are necessary to avoid physical harm and emotional suffering;

[5] SEXUAL ASSAULT;

[6] DOMESTIC VIOLENCE INJURIES;

[7] HUMAN TRAFFICKING;

[8] LEGAL PROCEEDINGS: information will be disclosed in response to a court order, subpoena, or other lawful process;

[9] ANIMAL BITES;

[10] CORONERS AND FUNERAL DIRECTORS: I may disclose PHI to a coroner or medical examiner to permit identification of a body, determine cause of death, or for other official duties. I may also disclose PHI to funeral directors.

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California-Specific Protections:

California law provides additional protections for certain types of information. We will obtain your written authorization before disclosing:

[1] PSYCHOTHERAPY NOTES (with limited exceptions);

[2] ABORTION-RELATED SERVICES;

[3] HIV/AIDS TEST RESULTS (except the required report to the department of public health);

[4] GENETIC TEST RESULTS;

[5] SUBSTANCE USE DISORDER TREATMENT RECORDS (as required by federal and state law);

[6] California law may provide stricter standards than federal law. When this occurs, we follow the stricter standard.

Interpreter Services

Interpreter services can be arranged if needed. Professional medical interpreters are required by law to protect patient confidentiality. If you choose your own interpreter, confidentiality cannot be guaranteed.

Your Rights:

The following is a statement of your rights with respect to your protected health information;

[1] You have the right to access and copy your protected health information. Under federal law, however, you may not access or copy the following records: psychotherapy notes; information to be used in a civil, criminal, or administrative proceeding;

[2] If you believe your information is incorrect or incomplete, you may request a correction or amendment;

INITIAL HERE: _____

[3] You have the right to request restrictions on certain uses and disclosures of your protected health information for the purposes of treatment, payment or healthcare operations. I am not required to agree, except when you request that I not disclose information to your health plan regarding services you paid for in full out of pocket. If you do this, expect that your insurance company will not pay for the associated costs of treatment;

[4] While you may ask me not to disclose specific parts of your protected health information, it is my responsibility to keep a written record of all professional medical advice that I provide to you. If you ask me to not record in my record specific parts of your protected health information, I will not provide you with professional medical advice regarding the excluded information;

[5] You may request an accounting of disclosures. This means you may ask me to tell you whom I shared your information with in the last 6 years;

[6] You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction and to whom you want the restriction to apply;

[7] You have the right to receive confidential communications from me by alternative means or at an alternative location. For example, you may request lab results be mailed to a PO Box instead of your home address.

[8] You have the right to choose someone to act for you if you have granted them medical power of attorney.

[9] You have the right to obtain a paper copy of this notice from me, upon request. This notice will also be posted by my website www.drcapper.com.

Changes To This Notice:

I may change this Notice and my privacy practices at any time. Any revisions will apply to both past, present, and future health information about you. You will promptly be notified of any changes and asked to sign

INITIAL HERE: _____

the new Notice. You may revoke your authorization for me to use your information at any time.

Breach Notification:

If your unsecured protected health information is compromised, I will notify you as required by law.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with:

Our Practice Privacy Officer Benjamin Capper M.D.
Address: 1000 Newbury Rd, Ste 105, Newbury Park, CA, 91320.
Email: me@drcapper.com.

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Right.

[1] You may file this complaint using their online portal at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf;

[2] Sending an email to OCRComplaint@hhs.gov;

[3] Mailing a completed “Civil Rights Discrimination Complaint Form Package" to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 509F HHH Bldg.,
Washington, D.C. 20201.

You will not be retaliated against for filing a complaint.

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By signing this form, you acknowledge that you have read and understood the contents of this Notice of Privacy Practices, you have been given the opportunity to ask me clarifying questions and I have answered the to your satisfaction. You understand your right to revoke your authorization for me to use and disclose your information at any time. You agree to proceed with care with Dr. Benjamin Capper under the terms of this Notice.

SIGNATURE: _____

YOUR NAME: _____

DATE OF SIGNATURE: _____

RELATIONSHIP TO PATIENT (mark one):

_____ SELF

_____ MEDICAL POWER OF ATTORNEY

INITIAL HERE: _____