

HIPAA Notice of Privacy Practices

Medical Record

Used

Stored / Shared

Your Right to Access / Complain

This notice explains how your medical information may be used, disclosed, make a complaint if you felt your privacy has been violated and how you can get access to this information.

Please review this carefully.

| Your Rights | You have certain rights to your health information. |
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| Receive an electronic or paper copy of your medical record | <ul style="list-style-type: none">• Ask us how you can get an electronic or paper copy of your medical record and other health information we have on file.• A copy or summary of your health information should usually be ready within 30 days of your request. A fee may be charged. |
| Update your medical record | <ul style="list-style-type: none">• Ask us how to update your health information you think is incorrect or incomplete.• If for whatever reason we are unable to follow through with your request to update your incorrect or incomplete information, we will let you know why in writing within 60 days. |
| Confidential communications request | <ul style="list-style-type: none">• You can ask that we contact you from a location specified (i.e. home or office phone) or to send mail to a different an address not listed after we have verified you.• We will most likely say “yes” and do as you request as long as long as it is a reasonable one. |
| Ask to limit what we use or share | <ul style="list-style-type: none">• You have the right to ask us to not use or share certain health information for treatment, payment or our operations.<ul style="list-style-type: none">• If your request will affect your care, we might say “no” and may not be able to agree depending on the case.• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.<ul style="list-style-type: none">• We will say “yes” unless a law requires us to share that information. |

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| Receive a list of everyone your information files were shared with | <ul style="list-style-type: none"> You can ask for a list (accounting) of the number of times we've shared your health information with within six years prior to the request date, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (i.e. mainly any you asked us to not disclose). A reasonable cost-based fee may be charged on a case by case basis. |
| Receive a copy of this privacy notice | <ul style="list-style-type: none"> You can ask for a paper copy of this notice at any time even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| Choose someone to communicate on your behalf | <ul style="list-style-type: none"> If you have given someone medical power of attorney over your Protected Health Information or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will have to verify the person has this authority and can act for you before we take any action(s) or release your Protected Health Information to them. |
| File a complaint if you feel that your rights were violated | <ul style="list-style-type: none"> You can file a complaint when you feel that your privacy has been violated. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html. We will not retaliate against you for filing a complaint. |

| Your Decisions | You can decide on what you allow us to share regarding certain health information. |
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| | <i>If you have a preference on how we share your information in situations described below, let us know. Also let us know what you prefer and your suggestions and we can follow your instructions.</i> |
| In these cases, you have both the right and choice to tell us to: | <ul style="list-style-type: none"> Share information with your family, close friends or others involved in your care Share information in a disaster relief situation Include your information in a hospital directory <p><i>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety</i></p> |

| Our Uses and Disclosure | How do we typically use or share your health information? |
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| | <i>We typically use or share your health information in the following ways.</i> |

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| Treat you | <ul style="list-style-type: none"> We can use your health information to treat you and share it with other professionals who are treating you. | <p>Example: A doctor treating you for an injury asks another doctor about your overall health condition.</p> |
| Run our organization | <ul style="list-style-type: none"> We can use and share your health information to run our practice, improve your care, and contact you when necessary. | <p>Example: We use health information about you to manage your treatment and services.</p> |
| Bill for your services | <ul style="list-style-type: none"> We can use and share your health information to bill and get payment from health plans or other entities. | <p>Example: We give information about you to your health insurance plan so they will pay for your services.</p> |

| Our Uses and Disclosure | How else can we use or share your health information? |
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| | <p>We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.</p> |
| Help with public health and safety issues | <ul style="list-style-type: none"> We can share health information about you for certain situations such as: <ul style="list-style-type: none"> Preventing disease Reporting suspected abuse, neglect or domestic violence Preventing or reducing a serious threat to anyone’s health or safety |
| Do research | <ul style="list-style-type: none"> We can use or share your information for health research with your authorization and consent. |
| Comply with the law | <ul style="list-style-type: none"> We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law(s). |

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| Address workers' compensation, law enforcement, and other government requests | <ul style="list-style-type: none"> • We can use or share health information about you: <ul style="list-style-type: none"> • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services |
| Respond to lawsuits and legal actions | <ul style="list-style-type: none"> • We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

NOTES:

We do not create or manage a hospital directory.

We do not create or maintain psychotherapy notes at this practice.

We will never share any substance abuse treatment records without your written permission.

| Our Responsibilities | |
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| <ul style="list-style-type: none"> • We are required by law to maintain the privacy and security of your protected health information. • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it. • We will not use or share your information other than as described here unless you tell us we can in writing. After you have given us in writing your request, you can still and may change your mind at any time. Let us know in writing if you do change your mind. | |
| <p>Store your documents</p> | <ul style="list-style-type: none"> • We currently use a HIPAA compliant cloud based electronic health records (EHR) platform, Carepatron. <ul style="list-style-type: none"> • Forms for the patient/client: <ul style="list-style-type: none"> • HIPAA Notice of Privacy Practices • New Patient In-Take Form(s) • Consent Forms • Health Questionnaires for both: <ul style="list-style-type: none"> • Biomedicine • East Asian Medicine • Patient charts and forms to be filled out by the practitioner: <ul style="list-style-type: none"> • SOAP Notes • Medications List • Problems List • We may transition to another cloud based EHR platform in the future. • Your files may be printed on paper and filed in the traditional paper format. • We also have paper copies of forms for backup and reference in cases when electronic health records are inaccessible. |

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

NOTE:

We are not currently affiliated with any organizations at present.

Would you like a paper copy of this HIPAA Notice of Privacy Practices? *

Yes

No

ACKNOWLEDGMENT

By checking each box, I acknowledge that I have read and been informed about each of the following listed as they relate to my medical record(s) and Protected Health Information:

- Shared: Who my health information has been shared with.
- Stored: How my records are being stored.
- Access: My right to access my medical record through a request in writing.
- Complain: I can file a complaint when I feel that my privacy has been violated.

By signing this form, I acknowledge that I have read this **HIPAA Notice of Privacy Practices** and I understand my rights as a patient regarding my Protected Health Information (PHI).

Signature: *



Print / Type name: *

Date:

Witness Signature:

(If applicable)



Print / Type Name

Date: