HIPAA NOTICE OF PRIVACY PRACTICES
POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

Medical practices are legally required to maintain the privacy of identifiable health information, to give you this notice of legal duties and privacy practices with respect to your health information, and to follow the terms of this notice.

HOW YOUR MEDICAL INFORMATION MAY USED AND DISCLOSED:

For purposes of treatment - I understand that this acupuncture clinic will use my health care information for my diagnosis and treatment (acupuncture, electro-acupuncture, massage, cupping, gua sha, or herbs) purposes. I understand that my protected health information may be disclosed but not sold to another health care provider.

For payment services – I understand that my health care information may be used to receive payment for services and products, and that the information on or with the bill may include identifying information.

For health care operations – I understand that my protected health information may be disclosed for all activities that are included within the definition of "health care operations" as defined in the Federal Privacy Regulations.

Family, friends, and personal representatives – I understand that this practice may disclose my protected health information to family members, relatives, friends, personal representatives, or anyone involved with my healthcare in case of an emergency or to assist with my care, including payment, transportation, or general health condition.

Reminder calls, texts, or emails – I may be contacted by this acupuncture practice to provide reminders of my appointments, for treatment or care, herbal refills, or other health-related services.

Other covered entities – This acupuncture practice may disclose my protected health information to another covered entity to conduct health care operations for quality assurance.

Disclosure to the U.S. Department of Health and Human Services (DHHS) – When DHHS is investigating or determining compliance with federal privacy regulations, this practice is required to disclose protected health information to DHHS.

Abuse or neglect – Professional acupuncturists are considered mandated reporters by law, which requires disclosure of protected health care information to appropriate authorities if there is belief that an elderly individual or child may be a possible victim of abuse, domestic violence, neglect, or other crimes.

Serious threat to health or safety – This acupuncture practice may disclose my health information if the disclosure is believed to be necessary to prevent a serious threat to the health or safety of myself, the public, or another person.

Public health and safety – This acupuncture practice may release my protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, such as the Food and Drug Administration (FDA), regarding drugs, food, supplements, and other health products to enable product recalls or replacements.

patient/client initials _____

Business Associates – My protected health information may be disclosed to business associates of this practice that perform functions or provide services, such as insurance billing. All business associates are obligated under contract to protect health information privacy and are not allowed to use or disclose any information other than as specified in the contract.

Workers' compensation – My protected health information may be released if I am involved in a workers' compensation case. These programs may provide benefits for me during work-related injuries or illnesses.

Law enforcement – My protected health information may be disclosed to authorized local, state, or federal law enforcement agencies in response to a court order, subpoena, discovery request, administrative order, or other lawful process regarding a dispute, but only if efforts have been made to tell me about the request or to obtain an order protecting the requested health information.

Correctional institutions - My protected health information may be disclosed to a correctional institution or its agents if I become a patient of such a facility or when necessary for my health or the health and safety of others.

Military - My protected health information may be disclosed to military authorities under certain circumstances, when I am a member of the Armed Forces or a Veteran.

Treatment alternatives - My medical information may be used or disclosed in order to inform me about or to recommend possible treatment options or alternatives.

Other required or permitted disclosures – This acupuncture practice may disclose my protected health information under the following circumstances:
- Whenever legally required.
- To notify the appropriate government authority in cases of potential abuse, neglect, or domestic violence.
- To authorized federal officials for intelligence, counterintelligence, and other national security activities.
- For compliance audits by regulatory bodies or payers.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION

This notice describes rights regarding my personal medical information and obligations of this practice regarding the use and disclosure of this medical information. The law requires this practice to:

- Make sure medical information that identifies me is kept private;
- Give me this notice of legal duties and privacy practices with respect to my medical information;
- Follow the terms of this notice.

AUTHORIZED USE AND DISCLOSURE

I understand that this acupuncture practice will obtain my *written authorization* before using or disclosing my protected health care information for purposes other than those listed above or otherwise permitted/required by law. If I provide this practice permission to use or disclose my medical information, *I may revoke this authorization in writing at any time.* If I revoke my permission, this practice will no longer use or disclose medical information about me for the reasons covered by my written authorization, except to the extent that disclosure action may have already been taken when relying on previous authorization. I understand that this practice is unable to take back any previous disclosures already made with my permission, and that retaining records of the care that was provided to me is required.

patient/client initials _____

NOTICE OF INDIVIDUAL PATIENT RIGHTS

I understand that I have the following rights regarding medical information that this practice maintains about me:

Right to request restrictions
I understand that I have the right to request that this practice restrict how my protected health information (PHI) is used or disclosed in carrying out treatment, payment, or healthcare operations. Requests must be made in writing (see contact information in footer) and include: 1) the information to be limited and not disclosed, and 2) how information should be limited or not disclosed. I understand that this practice is not required to agree to the requested restrictions, but that if it does it will abide by the request except in cases of emergency.

Right to access protected health information
I understand that I have the right to look at or obtain a confidential copy of my PHI or billing information. Requests must be made in writing. I may be charged a reasonable fee for copies and postage. My request to inspect and copy my protected health information may be denied in certain limited circumstances, in which case I may request that the denial be reviewed.

Right to access electronic medical records
I understand that I have the right to look at or obtain a confidential copy of my electronic medical records. Requests must be made in writing. This practice may charge me a reasonable fee for copies and postage. My request to inspect and copy my protected health information may be denied in certain limited circumstances, in which case I may request that the denial be reviewed.

Right to accounting disclosures
I understand that I have the right to receive a list of my PHI disclosures made by this practice, including date of disclosure(s), name(s) of the person/entity to which my PHI was disclosed, a description of information disclosed, and the reason(s) for disclosure. Requests must be received in writing and indicate whether I want the list in paper or electronic form and for what time period.

Right to restrict disclosures to insurance companies
I have the right to restrict disclosures to an insurance company when I have paid for the treatment out-of-pocket. Restriction requests must be made in writing and state a restriction time period no longer than six years.

Right to amend my health care information
I understand that I have the right to request that this practice amend my protected health information if I feel that it is incomplete/incorrect for as long as the information is kept by/for this practice. Requests must be made in writing and include a list of the information to be amended and the reason(s) for the amendment. This practice may deny my request if it did not create the pertinent information, if there is no reason for the request, if my request is not in writing, or in other circumstances. If my request is denied, a written explanation will be provided at which time I have the right to file a statement of disagreement about the decision.

Right to inspect and copy
I have the right to inspect and copy my medical information that may be used to make decisions about my care, including medical/billing records. I must submit my request in writing. If I request a copy of the information, this practice is entitled to charge a fee for the costs of copying, mailing, or other supplies associated with my request.

Right to special protections for HIV, Alcohol/Substance Abuse, Mental Health, and Genetic Information
Special privacy protections apply to HIV-related information, alcohol and substance use information, mental health information, and genetic information. Some parts of this Notice of Privacy Practices may not apply to these types of information. If my treatment involves this information, I may contact this practice for more information about my protections.

Right to a paper copy of this notice.
I have the right to a paper copy of this notice. Even if I have agreed to receive this notice electronically, I may ask this practice to give me a paper copy of this notice at any time.

patient/client initials _____

Right to request confidential communications.
I have the right to request that this practice communicate with me about medical matters in a certain way or at a certain location. For example, I can request to be contacted only at work or by mail. To request confidential communications, I must make my request in writing, specifying how and where I wish to be contacted. This practice does not need to know the reason for the request and will accommodate all reasonable requests.

Right to privacy breach notice
I have the right to be notified if a breach occurs that may have compromised the privacy or security of my health information.

Email and Protected Health Information (PHI)

I understand that HIPAA regulations require that my protected health information (PHI) be kept secure and encrypted when sent via email. I understand that this practice will only use a secure electronic health record (EHR) system email portal to communicate electronically about my healthcare.

For More Information or to Report a Problems

Request more information
I understand that if I want additional information or have questions about these Privacy Practices, I may contact this practice.

Report a problem
If I believe my privacy rights have been violated, I may file a complaint with this practice or with the U.S. Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Ave, Washington, DC, 20201, or file a complaint online at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. To file a complaint with the clinic, please contact this practice in writing by using the contact information in the footer. I will not be penalized in any way for filing a complaint.

Changes to This Notice

This practice reserves the right to change this notice, and to make the revised or changed notice effective for health information we already have, as well as any information we receive in the future. This notice is effective as of August 15, 2021.

Signature_____**Printed Name** _____ **Date** _____