

HIPAA: NOTICE OF PATIENT INFORMATION PRACTICE

This notice describes how medical information about you may be used or disclosed by this Practice and how you can get access to information. Please review it carefully.

LEGAL DUTY - This practice is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described here.

USES AND DISCLOSURES OF HEALTH INFORMATION - This practice uses your health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. We may also use or disclose your personal health information for public health purposes, audits, emergencies and when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. We may change our policy at any time. When changes are made a new Notice of Information Practices will be posted in our office and you will receive a new written notice as well.

PATIENT'S INDIVIDUAL RIGHTS - You have the right to review or obtain a copy of your personal health information at any times. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. We will consider all such requests on a case by case basis, but the company is not legally required to accept them.

CONCERNS AND COMPLAINTS - If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

I have read and understand the above Notice **of Patient Information Practices**. I understand that Integrative Wellness Physical Therapy & Consulting may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company. I also understand that this practice will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Integrative Wellness's **Notice of Patient Information Practices**. In doing so, I hereby release Integrative Wellness Physical Therapy & Consulting from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

Patient and Parent/Guardian's Printed Name if Patient is under 18

Signature

Date

Print

Date