

Sequoyah Acupuncture Clinic

HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Under the Health Insurance Portability & Accountability Act of 1996 "HIPPA," it is our legal duty to safeguard your Protected Health Information (PHI). Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your health care information is fundamental in the course of our relationship. *This notice will remain in effect until it is replaced or amended by changes in the law.*

We gather personal information and health information in several ways:

- Information we receive from you;
- Information we receive from other healthcare providers; and
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.

You should be aware that during the course of our relationship we will likely use and disclose health information by submitting the authorization in writing. Such disclosure will be made to any personal representative you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters, and appointment reminders, by telephone, mail, or email.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of \$15 and we may take up to 10 working days to process your request.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restriction on the disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions about this Notice or any complaints about our privacy practices, please contact our office. Please send written complaints to the Secretary of the Department of Health & Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201.

This Notice went into effect on December 16th, 2007.

I acknowledge consent for use and disclosure of Protected Health Information and receipt of this Notice of Privacy Practices.

Signature of patient or patient's personal representative

Date

Printed name of patient or personal representative

Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature on this HIPAA Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____
