

ACU: HIPAA Notice of Privacy Acknowledgement

HIPAA NOTICE OF PRIVACY PRACTICES

Please review this notice carefully. It describes how medical information about you may be used and disclosed and how you can get access to this information. Please check each box appropriately.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your healthcare provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of The Healing Collective, and any other use required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a diagnostic laboratory that provides service to you. As another example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

We may use or disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff and healthcare providers, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical providers or students that we are mentoring at our office. In addition, we may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use required by law:

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services.

YOUR RIGHTS

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

You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.



The Healing Collective
6800 N 79th St, Suite 202
Niwot, Colorado, US - 80503

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may have the right to have your provider amend your protected health information:

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please submit your digital signature below.

By signing and submitting this form, I acknowledge that I have been provided ample opportunity to read this document, or that it has been read to me. I acknowledge that I have received the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Name of Patient: * _____

Name of Guardian (if applicable): _____

Date * _____

PATIENT SIGNATURE * _____