MICHELLE MANTO
Berkshire Acupuncture & Wellness
Helping People Heal

PRIVACY OF INFORMATION CONSENT

Name: ____________________________________ Today's date: _____________

Our *Notice of Privacy Practices* (below) provides information about how we may use and disclose protected health information about you. The notice contains a *Patient Rights* section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- This Practice has a *Notice of Privacy Practices* and that the patient has the opportunity to review this notice.
- This Practice reserves the right to change the *Notice of Privacy Policies*.
- The patient has the right to restrict the uses of their information but this Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- This Practice may condition treatment upon the execution of this consent.

____ ________________
Patient Signature Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Keep this for your records.

USES AND DISCLOSURES: Here are some examples of how we might use or disclose your health care information: (1) Your acupuncturist or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment and treatment of your health condition. (2) Your acupuncturist or a staff member may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run their practice. (3) Your acupuncturist or a staff member may need to use your name, address, phone number and your clinical records to contact you to provide appointment reminders, information about treatment alternatives or other health related information that may be of interest to you *(164.520(b) (1) (iii) (A).* You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you. You may inspect or copy the information that we use to contact you to provide appointment reminders, information on treatment alternatives or other health related information any time.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION: You may revoke your authorization, in writing, to us at any time. There are two circumstances under which we will not be able to honor your revocation request: (1) If we have already released your health information before we receive your request to revoke your authorization (*164.508(b) (5) (I).* (2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

OTHER PERMTTED USES AND DISCLOSURES WITHOUT CONSENT OR AUTHORIZATION: Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances: (1) If we are providing health care services to you based on the orders of another health care provider. (2) If we are providing health care services to you as an inmate. (3) If we are providing health care services to you in an emergency. (4) If we are required by law to treat you and are unable to obtain your consent after attempting to do so. (5) If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. Other than the circumstances described in the examples above and in the USES AND DISCLOSURES section of this notice, any other use or disclosure of your health information will only be made with your written authorization.

YOUR RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES MADE OF YOUR RECORDS: You have the right to request an accounting of the disclosures we have made of your health information for the last six years before the date of your request. A fee may apply. When making a request we will tell you the amount of the fee and you may withdraw or modify your request at that time. The accounting will include all disclosures except these disclosures: (1) Required for treatment, to obtain payment for services, or to run our practice. (2) Made to you or those involved in your care. (3) Necessary to maintain a directory of the individuals in our facility. (4) For national security or intelligence purposes, as required by

law. (5) Made to correctional officers or law enforcement officers, as required by law. (6) That was made prior to the effective date of the HIPAA privacy law.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES: If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

OUR PRIVACY PLEDGE: We have and always will respect your privacy. Other than the uses and disclosures described within this notice, we will not sell or provide any of your health information to any outside marketing organization.

YOUR RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION REGARDING YOUR HEALTH INFORMATION: We normally provide information about your health to you in person at the time you receive services. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like that information in a different format. To help us respond to your needs, please make any request in writing.

YOUR RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION: You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. A fee may apply for any copies requested.

YOUR RIGHT TO AMEND YOUR HEALTH INFORMATION: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records be in writing with a reason to support the change you are requesting us to make.

RE-DISCLOSURE: Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

OUR DUTIES: We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we preserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

YOUR RIGHT TO COMPLAIN: You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint. While you may make an oral complaint at any time, written comments should be addressed to Michelle Manto, Licensed Acupuncturist, or Berkshire Acupuncture & Wellness at our address shown on this notice.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE: If you have agreed to receive privacy notices by email, you may request a paper copy of this notice at any time.