**YOUR HEALTH INFORMATION PRIVACY RIGHTS**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent.

 ***As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:***

 **• For your treatment and care coordination, multiple health care providers may be involved in your treatment directly and indirectly.**

**• With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.**

**• To protect the public’s health, such as reporting when there is a communicable disease in your area.**

**• To make required reports to the police, such as life threatening injuries.**

**• Obtain payment from third party payers.**

***In order to provide you with service that best meets your privacy needs, please let us know if any of the contact information you provided should not be used.***

Please check any that apply:

**☐ Please do not phone me at home. Use this alternate phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**☐ Please do not phone me at work. Use this alternate phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**☐ Please do not leave messages on my answering machine. Alternate message phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**☐ Please do not contact me by email.**

**☐ Please send mail, including my bills, to this alternate address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**☐ Other request (please describe):**

**Your Health Information Rights**

**• You have the right to request restrictions on certain uses and disclosures of your health information.**

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

**• You have the right to request amendments be made by this office to your protected health information file.**

**• You have a right to receive an accounting of disclosures of your protected health information.**

**• You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.**

**By way of my signature, I authorize Vital Spirit Naturopathic, LLC and Dr. Meredith Peyton, ND to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.** **Please sign to indicate you have read and understand your medical privacy rights. If you have questions about this notice or of you want more information, please contact:**

**Vital Spirit Naturopathic, LLC**

**Dr. Meredith Peyton, ND**

***Patient Printed Name* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Patient Signature (Parent/guardian signature if minor)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Date* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**