NOTICE OF PRIVACY PRACTICES (HIPAA)
Protecting Your Privacy

At Restore True Health, I am committed to protecting the privacy and confidentiality of your health information. This Notice explains how your Protected Health Information (PHI) may be collected, used, and disclosed, your rights regarding your health information, and my responsibilities under the Health Insurance Portability and Accountability Act (HIPAA).

Protected Health Information (PHI) includes information about your (or your child's) health history, consultations, assessments, recommendations, laboratory results, correspondence, and any records created during services provided through Restore True Health.

Please read this Notice carefully. By signing the acknowledgment at the end of this document, you confirm that you have received and had the opportunity to review this Notice of Privacy Practices.

How Your Health Information May Be Used

Your Protected Health Information may be used or disclosed for the following purposes:

Providing Your Care
Your information may be used to:

- Conduct homeopathic consultations
- Provide nutritional consultation and wellness coaching
- Review laboratory or functional testing results
- Develop individualized wellness recommendations
- Maintain accurate clinical records
- Provide follow-up care and ongoing support

Administrative & Business Operations
Your information may be used as reasonably necessary to:

- Maintain client records
- Schedule appointments
- Process payments and issue receipts
- Improve practice operations
- Comply with legal and professional obligations

Professional Consultation
From time to time, I may consult confidentially with qualified healthcare professionals or professional colleagues regarding a case when I believe doing so may benefit your care.
Whenever possible, identifying information will be omitted, and only the minimum information necessary will be shared. Any professionals consulted are expected to maintain appropriate confidentiality.

When Information May Be Disclosed
Your Protected Health Information will not be released without your written authorization except when permitted or required by law.
Examples include:

- Reporting suspected child abuse or neglect
- Reporting abuse or neglect of a vulnerable adult
- Compliance with a valid court order
- Public health reporting when legally required
- Situations involving an imminent threat of serious harm to yourself or another individual

Whenever possible, only the minimum necessary information will be disclosed.

Electronic Communication
Restore True Health may communicate with you using:

- Email
- Telephone
- Text message
- Secure video conferencing platforms

These methods may be used for:

- Appointment scheduling
- Follow-up communication
- Educational resources
- Administrative matters
- Recommendations related to your care

Although reasonable safeguards are used to protect your privacy, electronic communication cannot be guaranteed to be completely secure. By signing this acknowledgment, you consent to these methods of communication unless you notify me otherwise.

Your Rights
Under HIPAA, you have the right to:

- Request a copy of your health records.
- Request corrections if you believe information is inaccurate or incomplete.
- Request restrictions on certain uses or disclosures of your information.
- Request confidential methods of communication whenever reasonably possible.
- Receive a paper copy of this Notice at any time.
- File a complaint if you believe your privacy rights have been violated.

Children Receiving Services
When services are provided to a minor, the child's parent or legal guardian is generally considered the personal representative and may access the child's Protected Health Information, except where otherwise provided by applicable law.

Commitment to Confidentiality
I am committed to protecting your privacy and maintaining the confidentiality of your health information. Health records are stored securely and accessed only as necessary to provide services, comply with legal obligations, or fulfill professional responsibilities.

Questions
If you have any questions regarding this Notice of Privacy Practices or how your information is handled, please feel free to ask.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received and had the opportunity to review the Restore True Health Notice of Privacy Practices.

I understand how my (or my child's) Protected Health Information may be collected, used, and disclosed, and I understand my rights under HIPAA.

Client Name: _____
(If the client is a minor, please print the child's name.)

Parent/Guardian Name (if applicable): _____

Signature: _____

Date: _____