

# **VB Acupuncture**

Notice of Privacy Practices as it applies to the utilization of Acupuncture Services

*Please review the information below carefully*

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

## ***The Health Insurance Portability and Accountability Act of 1996 (HIPPA):***

HIPPA is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form are kept confidential. This act provides the patient rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

## ***Our Responsibility:***

We respect our legal obligation to keep health information that identifies you private. As obligated by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use it and disclose your health care information. We do not use your health information inside our office without your written permission. In some limited cases, the law requires us to disclose your health care information without either a written or verbal consent.

We promise to keep the following safeguards in place:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including mail, e-mail, telephone, and faxes) are kept private on permanent file.

## ***Use and Disclose With Consent:***

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and health care operations in this office. Treatment can be stopped with refusal to sign the form. We are permitted to use and disclose health information to a family member or other personal representative to the extent necessary to help with your health care. Before we disclose your medical information to a person involved in your health care or payment for your health care, we will provide you with an opportunity to object to such uses and disclosures. In addition, we may use your confidential information to remind you of

appointments by leaving you messages at home or work. Any other uses and disclosures will be made only with your written authorization.

### ***Use and Disclosure Without Consent:***

In some limited situations, the law requires us to use and disclose your health information without your permission. These include:

- When state or federal law mandates certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims or suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of health care laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime in our office.
- Disclosure related to worker's compensation programs.

### ***Your Rights Regarding Your Health Information:***

You have the following rights with respect to your protected health information, which you can exercise in writing to our office:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to ask to communicate with you in a confidential way, such as contacting you at work rather than at home. Please provide a written request.
- The right to see or receive photocopies of your health information. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. Please complete our written records request for billing or medical records release.
- The right to receive an accounting disclosure of protected health information.
- If you feel that medical information we have about you is incorrect or incomplete, you have the right to amend your protected health information.
- The right to obtain a paper copy of this notice at your request.

**Changes to this Notice:**

We reserve the right to change this notice. We reserve the right to make the revised notice effective for medical information we have on file for you, as well as any information we receive in the future. We will post a copy of the current notice in our office.

You have the right to file a formal, written complaint with the Secretary of the US Department of Public Health and Human Services in the event you feel your privacy rights have been violated.

I request the following restrictions to the use of disclosure of my health information:

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Signature

\_\_\_\_\_  
Date