HIPPA Release Form

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. We do not use your health information inside our outside 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. Safeguards in place at our office are:

1. **Limited access to facilities where information is stored.**
2. **Policies and procedures for handling information.**
3. **Requirements for third parties to contractually comply with privacy laws.**
4. **All medical files and records are kept on permanent file.**

Use and Disclose with your 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. It is a requirement to sign our HIPPA Information and Disclosure Consent form in order to get treatment in our clinic.

We are permitted to use and disclose health information to a family member or other personal representative or health care practitioner to the extent necessary for your healthcare. In addition, we may use your confidential information to remind you of appointments by leaving you messages at the phone numbers provided by you. Any other uses and disclosures will be made only after your formal written request and authorization.

Use and Disclosure without your consent: in some limited situations, the law requires us to use and disclose your health information without your permission. These exemptions include:

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

Your Rights Regarding Your Health Information…

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

1. **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. We are, however, not required to agree to the request restriction. If we do agree the restriction, we must abide by it unless you agree in writing to remove it.**
2. **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. You also have the right to see or request copies of your health information. We may charge a processing fee to release your records to an outside source other than a health care provider. Please notify us in writing of your request in a timely manner.**
3. **The right to receive an accounting disclosure of protected health information.**
4. **The right to amend your protected health information.**
5. **The right to obtain a copy of this notice at your request.**

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.

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Please read and answer the following questions:

Do you give our office permission to discuss your medical information with any of your family members and/or friends?

Yes _____ No _____

If yes, please provide names and phone numbers below:

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Signature: _____ Date: _____

Do you give our office permission to release and/or discuss your medical information with any of your primary care doctor or any other health care practitioner authorized by you?

Yes _____ No _____

If yes, please provide names and phone numbers below:

Doctor's Name: _____ Practice's name and location: _____

Phone Number: _____

Practitioner's Name: _____ Practice's name and location: _____

Phone Number: _____

Signature: _____ Date: _____

May we leave personal information related to your appointments and treatments at our clinic on your answering machine or voicemail?

Yes _____ No _____

Signature: _____ Date: _____

Receipt of Notice of Privacy Practices:

My Signature below indicates that I have reviewed a copy of my Physician's Notice of Uses and Disclosures of Protected Medical information. (Notice of Privacy Practices, HIPAA)

Signature: _____ Date: _____

S. Vanessa Navas, Acupuncture Physician
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