



NOTICE OF PRIVACY PRACTICES
Health Insurance Portability and Accountability Act (HIPAA)

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.

We understand that medical information about you and your health is personal and we respect your right to privacy. Protecting your privacy and healthcare information is fundamental in the course of our relationship. In administering your health care, we gather and maintain information that may include non-public personal information from your patient record, including diagnostic information, as well as the care and services you receive, your medical history, treatment notes, billing transactions, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

Disclosure of Information

In order to maintain the level of service that you expect from our office, we may need to share limited information for treatment, payment and healthcare operations. For example: **Treatment:** We may disclose medical information about you to other health care practitioners who are involved in your care in order to coordinate different types of treatment or to assist you and your physician or other health care providers in providing appropriate care for you. **Payment:** A receipt or bill may be sent to you or a third party payer that includes information that identifies you, as well as your diagnosis, medical information, procedures, herbs prescribed and supplies used. **Health Care Operations:** We are allowed to disclose your medical information if that is necessary for our office to function efficiently, safely, and in accordance with the law.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or disclose your medical information, you may cancel that permission in writing, at any time. Once we receive written notice that you are canceling permission we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

Patient Rights

Your health record is the physical property of Balanced Function Acupuncture, LLC, however you have the right to inspect and request a copy of your health record, request a restriction on certain uses and disclosures of your information, request that we amend your health record as provided by law, obtain an accounting of certain disclosures of your health information as provided by law, and obtain a paper copy of this notice of information practices upon request. You may exercise your rights by providing us with a written request.

Privacy Safeguards

Our clinic limits access to facilities where information is stored and upholds strict policies and procedures for handling private information. All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file. We will not use or disclose your health information without your written authorization, except as described in this notice or as permitted by law. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. If you have questions regarding privacy guidelines or would like more information, please contact: Balanced Function Acupuncture, LLC at 720-460-0232 or balancedfunctionacupuncture@gmail.com.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and consent to the “Notice of Privacy Practices” of Balanced Function Acupuncture, LLC. I understand that I may receive a copy of the above “Notice of Privacy Practices” and may ask any questions about the notice prior to signing this document.

PATIENT NAME (please print):

PATIENT SIGNATURE:

DATE: