



Notice Of Privacy Policies

THE FOLLOWING IS THE PRIVACY OF PALMS ACUPUNCTURE & WELLNESS AS DESCRIBED IN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) OF 1996. HIPPA REQUIRES PALMS ACUPUNCTURE & WELLNESS BY LAW TO MAINTAIN THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION AND TO PROVIDE YOU WITH NOTICE OF PALMS ACUPUNCTURE & WELLNESS'S LEGAL DUTIES AND PRIVACY POLICIES WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION.. WE ARE REQUIRED BY LAW TO ABIDE BY THE TERMS OF THIS PRIVACY NOTICE.

YOUR PERSONAL HEALTH INFORMATION

WE COLLECT PERSONAL HEALTH INFORMATION FROM YOU THROUGH TREATMENT, PAYMENT AND RELATED HEALTHCARE OPERATIONS, THE APPLICATION AND ENROLLMENT PROCESS, AND/OR HEALTHCARE PROVIDERS OR HEALTH PLANS, OR THROUGH OTHER MEANS, AS APPLICABLE. THE LAW SPECIFICALLY PROTECTS HEALTH INFORMATION THAT CONTAINS DATA, SUCH AS YOUR NAME, ADDRESS, SOCIAL SECURITY NUMBER, AND OTHERS, THAT COULD BE USED TO IDENTIFY YOU AS THE INDIVIDUAL PATIENT WHO IS ASSOCIATED WITH THAT HEALTH INFORMATION. THIS OFFICE MAY SEND BIRTHDAY CARDS, NEWSLETTERS AND APPOINTMENTS REMINDERS (TELEPHONE, TEXT, EMAIL, LETTER, ETC.)

USES OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION

GENERALLY, WE MAY NOT USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION WITHOUT YOUR PERMISSION. THE FOLLOWING ARE THE CIRCUMSTANCES UNDER WHICH WE ARE PERMITTED BY LAW TO USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION.

AS REQUIRED BY LAW. WE MAY USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION TO THE EXTENT THAT SUCH USE OR DISCLOSURE IS REQUIRED BY LAW AND THE USE OR DISCLOSURE COMPLIES WITH AND IS LIMITED TO THE RELEVANT REQUIREMENTS OF SUCH LAW.

YOUR RIGHTS WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION

UNDER HIPPA, YOU HAVE CERTAIN RIGHTS WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION. IT IS YOUR RIGHT TO REQUEST THE FOLLOWING REGARDING YOUR PERSONAL HEALTH INFORMATION:

- RIGHT TO REQUEST RESTRICTIONS ON USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.
- RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS.
- RIGHT TO INSPECT AND COPY YOUR PERSONAL HEALTH INFORMATION.
- RIGHT TO REQUEST AMENDMENT OF YOUR PERSONAL HEALTH INFORMATION.
- RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION.

YOU MAY FILE A COMPLAINT WITH US AND WITH THE SECRETARY OF DH'S IF YOU BELIEVE THAT YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED. COMPLAINTS FILED WITH THE SECRETARY OF DH'S MUST BE FILED WITHIN 180 DAYS OF WHEN YOU KNEW OR SHOULD HAVE KNOWN THAT THE ACT OR OMISSION COMPLAINED OF OCCURRED.

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
DHHS (OFFICE OF CIVIL RIGHTS)
200 INDEPENDENCE AVE SW ROOM 509 BUILDING F
WASHINGTON, DC 20201

IF YOU HAVE ANY QUESTIONS OR WANT MORE INFORMATION REGARDING HIPPA, PLEASE CONTACT US.

SIGNATURE _____ DATE _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY
INDICATE RELATIONSHIP IF SIGNING FOR PATIENT