NOTICE OF PRIVACY POLICIES

Under the Health Care Portability and Accountability Act (HIPAA), I am required to inform you of the ways this office keeps your health information confidential. You must sign a paper saying you received this information.

For me to disclose health information about you using your name or other information that would identify you, you must sign a written release:

1) Specifying to whom and under what conditions your written medical record can be released.
2) For me to speak with another health care provider about your case using your name.
3) For me to discuss your health with members of your family.

I may discuss your case while not using your name or any information that would identify you as an individual with other health care providers or as an example in a teaching situation.

I will put confidentiality notices on all faxes and emails that pertain to specific information which identifies an individual.

You must sign a form giving consent to treatment, payment and the use of healthcare operations (use of needles, electrical stimulation, guasha, cupping, heat lamp, topical herbs, etc.)

I will be glad to answer questions about this policy.

_____ _____

Client Signature Date

_____ _____

Practitioner Signature Date