

## **Aspen Medical Massage, LLC Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health information is personal, and I am committed to protecting it. Your health information is also very important to my ability to provide you with quality care and to comply with certain laws. This notice applies to all records about your care that occurs at my office and to all medical information I keep about you. I am legally required to safeguard your protected health information (PHI). *In general, PHI is personally identifiable information about your physical or mental health or condition, health care, or the payments for your health care.*

**Effective Date:** This notice and the practices described in it are effective December 2003.

**Changes to my Privacy Practices and this Notice:** The HIPPA privacy practices and this notice may change at any time. Any change will apply to PHI I already have on file and to PHI received after the effective date of the change.

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

You have the right to:

- Obtain a copy of this notice upon request
- Request limits on uses and disclosures of your PHI
- Inspect and obtain a copy of your PHI
- Request correction of your PHI
- Receive a list of certain disclosures of your PHI
- Choose how we communicate with you

For details regarding each of these rights, including exceptions, restrictions, the procedures you must follow to enforce your rights, and the procedures I must follow in responding to your requests, please contact the Secretary of the Federal Department of Health and Human Services.

The law requires me to have your written authorization to some uses and disclosures. In other circumstances, the law allows me to use or disclose PHI without your written authorization. I will use and disclose your PHI to the fullest extent authorized by law.

### **Uses and Disclosures of PHI:**

- Treatment
- Payment
- Business related activities, such as to operate my office. I may provide your PHI to my attorneys, accountants, and other consultants to make sure I am complying with laws that affect us.
- Individuals involved in your care or payment for your care. I may disclose PHI to a family member or other person who I reasonably believe to be involved in your care or payment for your care, unless you object.

### **Certain Public Health and Other Government Requested Uses and Disclosures:**

If you consent, the law allows me to disclose PHI without your further written authorization in the following circumstances:

- When required by law. I disclose PHI when I am required to do so by federal, state, or local law.
- For public health activities
- For reports about victims of abuse, neglect, or domestic violence. I will disclose your PHI in these reports only if I am required or authorized by law to do so, or if you otherwise agree.
- For lawsuits and disputes
- To law enforcement
- To coroners, medical examiners, and funeral directors
- To organ procurement organizations

- For medical research
- To avert a serious threat to health or safety
- For specialized government functions
- To worker's compensation or similar programs

In general, I may disclose a minor patient's PHI to a parent or guardian, but I may deny the parent's access to the minor patient's PHI in some situations.

For some types of PHI, there may be additional restrictions on my uses or disclosures described above. For example, drug and alcohol abuse patient treatment information, HIV test results, mental health information, and genetic testing results are given greater protection under Colorado laws.

Other uses and disclosures of your PHI that are not covered by this notice, or the laws that apply to me, will be made only with your written authorization. If you give me written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorizations, I will no longer use or disclose your PHI for the purposes specified in the written authorization, except that I am unable to take back any disclosures I have already made with your permission, and I am required to retain certain records of the uses and disclosures made when the authorization was in effect.

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Federal Department of Health and Human Services. I will not retaliate against you for filing a complaint. This is your right to do so if you feel your rights have been violated.

**PRIVACY NOTICE SIGNATURE PAGE**

I hereby acknowledge receiving the Privacy Notice for Aspen Medical Massage, LLC. I understand Aspen medical Massage, LLC will use and disclose my Protected Health Information (PHI) to the fullest extent of the law.

**Acknowledgement:**

I acknowledge receiving a copy of this Privacy Notice.

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**Witness:**

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_