

Notice of Privacy Practices

Connecticut Integrated Naturopathics

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully before signing.

Federal law requires us to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form—whether electronically, on paper, or orally—are kept confidential. HIPAA gives you, the patient, new rights to understand and control how your health information is used. That law also requires us to give this explanation of how we maintain the privacy of your health information. We reserve the right to change our privacy practices, provided the changes conform to applicable laws. Before we make significant change in our privacy practices, we will change this notice and make a new notice available upon request.

We may use and disclose your medical records only for each of the following purposes:

- Treatment, payment, healthcare operations, healthcare reminders and for public benefit. Any other disclosure will require your written authorization.
 - TREATMENT means providing or managing health care and related services by one or more health providers.
 - PAYMENT means such activities as obtaining reimbursement for services, billing, or collection activities and utilization review.
 - HEALTHCARE OPERATIONS include the business aspects of running the practice.
 - HEALTHCARE REMINDERS means providing you with appointment reminders or to inform you of the changes in practice services or hours by such means as postcards, voicemail messages, or letters.
 - PUBLIC BENEFIT means the disclosure of information for the following reasons: for public health activities including disease and vital statistic reporting; to report abuse, neglect, or domestic violence; to health oversight agencies; to law enforcement offices pursuant to subpoenas and other lawful processing; to medical examiners and coroners; to avert a serious threat to health or safety; and, as authorized by state and federal laws.

Any other uses and disclosures will be made only with your authorization. You must give such authorization in writing to disclose your records for any purpose, including but not limited to having a copy sent to another physician or to receiving the copy for your own use. You may revoke such authorization in writing, and we are required to honor that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to your practitioner:

- The right to request restriction on certain use and disclosures of protected health information, including those related to disclosure to family members, relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it, unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.

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- The right to inspect or copy your protected health information. You must make a request in writing to obtain access to your health information. If you request copies, we may charge you a reasonable cost based fee that may include labor, copying costs, and postage. If you prefer, we may, but are not required to, prepare summary or explanation of your health information for a fee.
- The right to amend your protected health information. Your request must be in writing and must include the explanation why we should amend your records. We may deny your request under certain circumstances.
- The right to receive an accounting of disclosures of your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

You have recourse if you feel your privacy protection has been violated. If you want more information about our privacy practices, or have any question or concerns, please contact us using the information listed at the end of this notice. You may also submit a written complaint to the US department of Health and Human Services, office of Civil Rights about violations of provisions of this notice or the policies and procedures of our practice. We will not retaliate against you for filing a complaint.

I have read and understand the above stated information.

Patient's name _____

Legal guardian _____ Relationship to patient _____

Patient's/ guardian's signature _____

Date _____

For more information about HIPAA or to file a complaint:
The US Department of Health and Human Services
Office of Civil Rights
200 Independence Ave, SW
Washington, DC 20201
Phone 202.619.0257
Toll free: 877.696.6775

Contact us:
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