

Alpine Valley Wellness Center

NOTICE OF PRIVACY PRACTICES

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

At Alpine Valley Wellness Center (AVWC) we are committed to maintaining the confidentiality of your personal financial and health information. As part of providing care and services to you, we are required to maintain *Protected Health Information* or PHI. about you. State and federal law protects this kind of information by limiting its use and disclosure. A more extensive version of our Privacy Practices is available for viewing at our clinic.

Our legal obligations, based on Federal and State Laws, include:

- making certain that your protected health information is protected;
- giving you this Notice, which describes our legal obligations and privacy practices concerning your medical information;
- following the terms of this Notice, as is currently in effect;
- explaining how we can use and disclose your protected health information
- ensuring that privacy of information regarding billing/payment for your health care services is maintained;
- obtaining your written authorization to use or disclose your protected health information for reasons other than those listed below and permitted by law.

Our Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations

1. For treatment:

We may use and disclose your protected health information (PHI) to provide you with medical treatment and services, and to coordinate or manage your health care and related services. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

2. For Payment:

We may use and disclose your protected health information (PHI) so that treatment and services you receive from AVNHC can be billed to the appropriate party (e.g. you, an insurance company, or a third party) and payment can be obtained. For example, we may need to contact your insurance company to see if your health plan covers a certain laboratory test we would like to do.

3. For Health Care Operations:

We may use and disclose your protected health information (PHI) as necessary for our clinic operations. These uses and disclosure are made for a variety of reasons that include, but are not limited to: quality of care, medical staff activities, legal or regulatory concerns, employee evaluation, contractual or governmental obligations, health care contracting, business management or administration activities, insurance activities, or the sale or merging of any part of AVNHC.

Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object

1. As Required by Law:

We may disclose your protected health information when required to do so by federal, state, or local law as well as other judicial or administrative proceedings.

2. Emergencies:

We may use or disclose protected health information as necessary in emergency treatment situations.

3. Public health reporting.

Your protected health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

4. Reporting Victims of Abuse or Neglect:

We may use and disclose your protected health information to notify a government authority when authorized by law, or if you agree to the report, if we believe that you have been a victim of abuse or neglect.

5. Individuals Involved in Your Care or Payment for Your Care:

We may disclose protected health information about you to a family member, relative, close personal friend or any other person you identify, including clergy, who is involved in your care.

6. Research:

In limited situations, your protected health information may be used for research purposes, subject to the confidentiality provisions of state and federal law, provided that the privacy and safety aspects of the research have been reviewed and approved by an institutional review board or a privacy board.

7. Health Oversight Activities:

We may disclose your protected health information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law. A health oversight agency is a state or federal agency that oversees the health care system.

Uses and Disclosures of PHI with Your Written Permission

Except for those circumstances listed above, we will use and disclose your protected health information only with your written authorization. You may revoke your authorization, in writing, at any time. If you revoke an authorization, we will no longer use or disclose your protected health information for the purposes covered by that authorization. However, your decision to revoke the

authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

The medical information generated about you within our clinic in the course of providing medical services for you is the property of AVNHC. However, you have the following rights regarding your personal health information we maintain about you:

- 1. The Right to Access Your Protected Health Information.** With certain exceptions, and upon written request, you have the right to inspect and obtain a copy of your protected health information (PHI). We may charge a reasonable, cost based fee for copies.
- 2. The Right to Request an Amendment or Addendum.** If you feel that medical information, billing records, or other protected health information maintained by us is incorrect or incomplete, you may ask us to amend the information or add an addendum for as long as the information is kept by us.. Your request must be made in writing and must explain the reasons for the requested amendment.
- 3. The Right to Request Restrictions.** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to your request.
- 4. The Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- 5. The Right to An Accounting of Disclosures.** You have the right to request an accounting of certain disclosures of your protected health information made after April 14, 2003.
- 6. The Right to a Paper Copy of This Notice.** You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting our office in writing or by phone.
- 7. Right to provide an authorization for other uses and disclosures.** Our clinic will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with AVNHC or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

1. To file a written complaint with AVWC, please contact us in writing at:
Alpine Valley Natural Health, Privacy Officer
430 Elva Way
East Wenatchee, WA 98802
2. To file a complaint with the federal government, you may contact:
Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 509F
HHH Building
Washington, D.C. 20201

Acknowledgement of Receipt of Notice of Privacy Practices

Changes to this Notice

We reserve the right to revise this notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect.

Consent

I have received a copy of the **Notice of Privacy Practices** from Alpine Valley Wellness Center (**AVWC**). I hereby give my consent for **AVWC** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **AVWC** may decline to provide treatment to me.

Signature of Patient _____

Signature of Patient Representative (If the patient is a minor or an adult who is unable to sign this form)

Name of Patient (Print or Type) _____

Date _____

Relationship of Patient Representative to Patient _____