



**HIPAA Notice of Privacy Practices For
Hopkins Health & Wellness Center
15 8th Avenue North, Suite 1
Hopkins, MN 55343
952-933-5085**

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

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health or condition and related to health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your Doctor, Physical Therapist, our office staff, and others outside of our office who are involved in you care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes coordination or management of your health care with a third party. For example, your protected health information may be provided to another provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name each time you come in for an appointment. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of or reschedule appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers' Compensation and Inmates. Under the law, we must make disclosures to you and when

required by the Secretary of the Department of Health & Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent. Authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that our office has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our office is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your provider amend your protected health information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective immediately.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask us to speak to our HIPAA compliance officer in person or by phone at 952-933-5085.

Signature below is only acknowledgement that you have received this Notice of Our Privacy Practices.

Print Name _____

Signature _____

Date _____

**CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR PURPOSES OF BILLING, TREATMENT, AND FILE MAINTENENCE**

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. Our Notice provides a description of our treatment, payment activities and health care operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before you sign this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our Contact Person. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health care information to carry out treatment, payment activities and health care operations.

Signature _____ Date _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name _____

Relationship to Patient _____

Your are entitled to a copy of this consent after you sign it.

