HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date*: *5/01/07

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.

If you have any questions about this notice, please contact: *Susan D. Engle, MOE, RD, LD at (603)658-0440 or by email at: susan.engle@comcast.net*

PLEDGE REGARDING PROTECTED HEALTH INFORMATION:

I, Susan D. Engle, MOE, RD, LD understand that protected health information about you and your health is personal. I am committed to protecting health information about you. This Notice applies to all of the records of your care generated by me.

This Notice will tell you about the ways in which I may use and disclose protected health information about you. It also describes your rights and certain obligations I have regarding the use and disclosure of protected health information. The law requires me to:

- make sure that protected health information that identifies you is kept private;
- notify you about how I protect protected health information about you;
- explain how, when and why I use and disclose protected health information;
- follow the terms of the Notice that is currently in effect.

I am required to follow the procedures in this Notice. I reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that is maintained in this office by:

- posting the revised Notice in the office
- making copies of the revised Notice available upon request;

HOW I MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that I use and disclose protected health information without your written authorization.

For Treatment. I may use protected health information about you to provide you with, coordinate or manage your medical treatment or services. I may disclose protected health information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. I may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment here or to recommend possible treatment options or alternatives or health-related benefits or services that may be of interest to you.

For Payment for Services. I may use and disclose protected health information about you so that the treatment and services you receive here may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations. I may use and disclose protected health information about you for health care operations, such as quality assessment and improvement activities, case management, coordination of care, business planning, customer services and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all patients receive quality care. Subject to applicable state law, in some limited situations the law allows or requires me to use or disclose your health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur through this office.

As Required By Law. I will disclose protected health information about you when required to do so by federal, state or local law. For example if you are involved in a lawsuit or dispute, I may disclose your information **in response to a court or administrative order**. As required by law, I may disclose your protected health information to **public health or legal authorities** charged with preventing or controlling disease, injury, or disability. I may disclose protected health information about you to a government authority if I reasonably believe you are a **victim of abuse, neglect, or domestic violence**. I may disclose protected health information to a **health oversight agency** for activities authorized by law, such as: audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws. I may release protected health information **in response to an order or warrant of a court, a subpoena, or an administrative request** if the law requires. I may disclose information as necessary to comply with laws relating to **worker's compensation** or other similar programs. I may disclose to the **FDA**, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research. I may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES

Unless you object, or request that only a limited amount or type of information be shared, I may use or disclose protected health information about you in the following circumstances:

- I may share with a family member, relative, friend or other person identified by you, protected health information directly relevant to that person's involvement in your care or payment for your care. I may also share information to notify these individuals of your location, general condition or death.
- I may share information with a public or private agency (ex: Am. Red Cross) for disaster relief purposes. Even if you object, I may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to the contact person listed on page 1 of this Notice (Susan D. Engle).

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.
You have the following rights regarding protected health information I maintain about you:

You have the **right to inspect and copy** protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records. If you feel that protected health information I have about you is incorrect or incomplete, you have the **right to ask me to amend or supplement** the information. You have the right to request an "**accounting of disclosures**." This is a list of the disclosures I made of protected health information about you. You have the **right to request a restriction or limitation** on the protected health information I use or disclose about you for treatment, payment or health care operations or to persons involved in your care. You have the **right to a paper copy** of this Notice at any time by contacting Susan D. Engle, MOE, RD, LD.

Right to Request Confidential Communications. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail.

OTHER USES AND DISCLOSURES

I will obtain your written authorization before using or disclosing your protected health information for purposes other than those provided for above. You may revoke this authorization in writing at any time. Upon receipt of the written revocation, I will stop using or disclosing your information, except to the extent that I have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT THESE PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with Susan D. Engle, MOE, RD, LD or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within180 days of the occurrence or action that is the subject of the complaint.

If you file a complaint, I will not take any action against you or change my treatment of you in any way.

Patient Written Acknowledgment Confirming Receipt of Privacy Notice

I have received a HIPAA Privacy Notice from Susan D. Engle, MOE, RD, LD, Nutrition Therapist, Registered Dietitian.

_____ _____

Client Signature Date

Patient Written Acknowledgment Confirming Receipt of Cancellation Policy

I have received a copy of Nutrition Matters' Cancellation Policy and I understand that if I do not provide 24 hours notice before changing or cancelling an appointment or if I do not show for a scheduled appointment I will be charged $35.00.

_____ _____

Client Signature Date

Communication Policies

I permit Nutrition Matters to leave telephone messages for me at work. **Yes No**

I permit Nutrition Matters to leave telephone messages for me at home. **Yes No**

I understand that e-mail may not be very secure but I still permit Nutrition Works! LLC to communicate with me using e-mail. **Yes No** E-mail address:
_____

Nutrition Works sends out an e-mail newsletter 2-4 times a year. It includes a recipe, interesting nutrition updates, and information about food and nutrition related things going on in our community. Would you like to receive this? **Yes No thanks**

I authorize the release of any medical or other information necessary to submit a claim to my health insurance company. I agree to pay Nutrition Matters for services rendered in the event that my insurance company does not cover them.
I understand and agree to the terms and conditions expressed herein.

Signed _____ Date _____