

## **NOTICE OF PRIVACY POLICIES (HIPAA)**

Zephyr Acupuncture and Bodywork is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

### **Marketing**

Zephyr Acupuncture and Bodywork will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, post cards or letters, unless otherwise advised by you.

### **Disclosure**

Zephyr Acupuncture and Bodywork may use or disclose your Protected Health Information when required by law.

### **Patient Rights**

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

To send a written complaint to the U.S. Department of Health and Human Services:  
DHHS (Office of Civil Rights)  
200 Independence Ave S.W. Room 509 F HHH Building  
Washington, DC 20201

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES**

I, \_\_\_\_\_, have read, reviewed, understand and agree to the statement of the Privacy Policies for healthcare services at the Zephyr Acupuncture and Bodywork.

I understand I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment of healthcare operations of the Acupuncture practice, but the practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

**I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information.**

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has acted in reliance on this consent.

***Signature of Patient or Personal Representative:***

***Date:***