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Notice of Privacy Practices

Pledge

The privacy of your health information is important to me. I am required by law to protect the privacy of your health information. I must give you notice of my legal duties and privacy practices concerning "protected health information" or PHI including:

1. I must protect PHI that I have created or received about you past, present or future health conditions, health care I provide to your or payment for your health care.
2. I must notify you about how I protect PHI about you.
3. I may only use/or disclose PHI as I have described in this notice.
4. I must abide by the terms of this notice.

I reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that I maintain. I will post a revised notice in my office, and make copies available to you upon request.

Minnesota Patient Consent for Disclosures
For most disclosures of your health information I am required by the State of MN Laws to obtain a written consent from you, unless the disclosure is authorized by law. This consent may be obtained at the beginning of your treatment, during the first delivery of health care service, or at a later point in your care, when the need arises to disclose your health information to others.

Uses and Disclosures

A. For purposed of treatment, Payment and Health Care Operations
   1. Health Care Treatment: I may use and disclose PHI about you to provide, coordinate, or manage your health care and related services. This may include communication with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others
   2. Payment: We may use and disclose your medical information to others to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as you diagnosis. Before you receive scheduled services, we may share information about these services with your health plans. Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide services. We may also share portions of your medical information with the following:
      a. My billing person
      b. Collection agencies
      c. Insurance companies, health plans and their agents

d. Utilization review personnel that review the care you received to check that it and the costs associated with in were appropriate.
e. Consumer reporting agencies.

B. Requiring your Authorization

In addition to our use of health information for treatment, payment or health care operations, you may give me written authorization, different from the MN Patient Consent, to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

C. Require your Opportunity to Agree or Object

In the following instances I will provide you the opportunity to agree or object to a use or disclosure of your PHI:

Notification: I may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, healthy information relevant to that person's involvement in your care or payment related to your care.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please contact me.

D. Authorized by Law that Do Not Require Your Consent, Authorization or Opportunity to Agree or Object

Under certain circumstances I am authorized to use and disclose your health information without your consent or authorization from you or giving you the opportunity to agree or object. These include:

1. When the use and/or disclosure is authorized or required by law.
2. When the use and/or disclosure is necessary for public health activities.
3. When the disclosure related to victims of abuse or neglect.
4. When the use and/or disclosure is for health oversight activities.
5. When the disclosure is for law enforcement purposes.
6. When the use and/or disclosure relates to decendents.
7. When the use and/or disclosure is to avert a serious threat to health or safety.
8. When the use and/or disclosure relates to specialized government functions.
9. When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations.

Your Individual Rights

A. To request restrictions on uses and disclosures of PHI.
   You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Dept. of Health and Human Services, and uses and disclosures described in this notice. You may request a restriction by submitting your request in writing to us. We will notify you if we are unable to agree to your request.
B. To request communications via alternative means or to alternative locations.
C. To see and copy PHI:
   You have the right to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. I may charge you related fees. Instead of providing you a full copy of the PHI; I may give you a summary or explanation of the PHI about you, if you agree in advance to the form and the cost of the summary or explanation. There are certain situations in which I am not required to comply with your request. Under these circumstances, I will respond to you in writing, stating why I will not grant this request and describing any rights you may have to request a review or my denial.
D. To request amendment of PHI
E. To request an accounting of disclosures of PHI.
F. To receive a copy of this notice.

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Signature of parent/guardian or client at least 18 years old Date