

Statement of Privacy Practices

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Our office is dedicated to protect the privacy and confidentiality of our patients protected health information (**PHI**) that is entrusted to us. We are required to give you this Notice about our privacy practices, and your rights concerning your **PHI**. We will follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 1, 2003 and will remain in effect until we replace it. We may from time to time amend our privacy practices and the terms of this Notice, but will inform you of any changes that affect your rights. You may request a copy of our Notice at any time from our office.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your **PHI**, with limited exceptions. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your **PHI**. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page. \$20.00 per hour for staff time to locate and copy your **PHI**, plus postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your **PHI**, plus a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your **PHI** for purposes of, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before 4/14/2003. You will be charged a reasonable, cost-based fee if you request this accounting more than once in a 12-month period.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your **PHI**. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your **PHI** by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your **PHI**. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances, and your request will become part of your file and **PHI**.

USES AND DISCLOSURES OF HEALTH INFORMATION:

Examples of use of your PHI include:

Treatment: Use or disclosure of your PHI to healthcare providers providing treatment and services.

Payment: We may use and disclose your PHI to obtain payment for services provided.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment/improvement activities in compliance with the contracts you have made with third party payors, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Appointment Reminders: We may use or disclose your PHI to provide you with appointment reminders such as voicemail messages, postcards or letters.

Marketing Health-Related Services: We will not use your PHI for marketing communications from third parties without your written authorization.

Required by Law: We must disclose your PHI when we are required to do so by law.

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Abuse or Neglect: We must disclose your PHI to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes in accordance with the Uniform Disciplinary Act. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We must disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We must disclose to authorize federal officers PHI requested for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected PHI or inmates or patients under certain circumstances.

Questions And Complaints: If you have questions/concerns or want more information about our privacy practices please contact our office. You may also contact the U. S. Department of Health and Human Services Office of Civil Rights. 200 Independence Avenue S.W., Washington D.C., 20201 (877) 696-6775.

Your Authorization: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI 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 of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this Notice.

Persons Involved In Care: We may use or disclose PHI to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose PHI based on a determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

To Your Family and Friends: We may send Thank You acknowledgments to the person who referred you to our office. We must disclose your PHI to you, as described in the Patient Rights section of this Notice. We may disclose your PHI to a family member, friend or other person to the extent necessary to help obtain payment for your healthcare. We will disclose your PHI to family or friends, subject to fees, only if you request that we may do so. List persons you request be allowed access to your PHI and/or additional restrictions as follows:

My signature confirms that I have been informed of my rights to privacy regarding my protected health information (PHI) under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Patient Name

Signature

Date

Guardian's Name

Signature

Date

The patient was presented with this form and declined to sign. Nicholas J. Friedman, ND, DC _____

Date