CLINIC OF NATURAL MEDICINE
A Center for Expert Care

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NOTICE OF PRIVACY PRACTICES

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

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. I understand that my **health information** may include information both created and received by the Clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Clinic may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- determine my eligibility for health plan or insurance coverage , and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care

As a patient, you have the following rights:

1. The right to inspect and copy your information:
2. The right to request corrections to your information:
3. The right to request that your information be restricted:
4. The right to request confidential communications:
5. The right to a report of disclosures of your information: and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Clinic's ***NOTICE OF PRIVACY PRACTICES.*** I understand that if I have questions or complaints regarding my privacy rights that I may contact The Clinic of Natural Medicine. I further understand that the Clinic will offer me updates to this ***NOTICE OF PRIVACY PRACTICES*** should it be amended, modified, or changed in any way.

_____

Patient or Representative Name (please print)

_____ _____

Patient or Representative Signature Date

☐ Patient refused to sign ☐ Patient was unable to sign because: _____