NOTICE OF PRIVACY PRACTICES

Wayne R. Nelson/Condition For Life
335 So. Spring Street, Klamath Falls, OR 97601

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

Each time you visit us, we keep a record of your care and treatment. We take the protection of your personal information seriously. We are required to provide you with this Notice of Privacy Practices to tell you about our legal duties and ways we may use and share your information, and to inform you about your rights regarding your health information. We give a small number of examples to describe what the categories mean, but not every use or disclosure can be listed on this Notice.

You have a right to a paper copy of this Notice of Privacy Practices.

This Notice is effective as of: February 1, 2014. We will ask you to sign a written acknowledgment of receipt of our Notice. We reserve the right to change the terms of this Notice and post the current Notice in our office. You may obtain an updated Notice from our practice at any time.

If you have any questions about this Notice of Privacy Practices, please contact our office.

How We May Use and Disclose Protected Health Information:

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and related services in our office or with a third party. For example, we may share your protected health information with a pharmacy for filling prescriptions, a laboratory or imaging center if you need diagnostic services, with a specialist to whom we refer you, or with a home health agency that provides care to you. We may share information with persons involved in your care, such as family members.

For Payment: We will use your protected health information to get paid for your healthcare services. We may share information with your insurance company to obtain payment for services or to seek pre-approval for a hospital stay or procedures.

For Our Healthcare or Business Operations: We may disclose your protected health information to support the business activities of this office, such as reviewing our care and our employees, for education and training, to support our electronic health record system, or for legal or accounting matters. We may use a sign-in sheet at the registration desk so that we may call you by name when we are ready to see you, and we may contact you to remind you of your appointment. If we involve third parties, such as billing services, in our business activities, we will have them sign a "business associate agreement" obligating them to safeguard your protected health information according to the same legal standards we follow.

When Allowed by Law: The law allows us to use or disclose your protected health information in certain situations, including:

- When required by state or federal law;
- To report abuse or neglect;
- To persons authorized by law to act on your behalf, such as a guardian, health care power of attorney or surrogate;
- For disaster relief purposes, such as to notify family about your whereabouts and

condition;

- For public health activities such as reporting on or preventing certain diseases;
- To comply with Food and Drug Administration requirements;
- For health oversight purposes such as reporting to Medicare, Medicaid or licensing audits, investigations or inspections;
- Where required by U.S. Department of Health and Human Services to determine our compliance;
- In connection with Workers' Compensation claims for benefits; and
- To assist coroners or funeral directors in carrying out their duties.
- To comply with a valid court order, subpoena or other appropriate administrative or legal request if you are involved in a lawsuit or to assist law enforcement where there was a possible crime on the premises. We may also share your information where necessary to prevent or lessen a serious or imminent threat to you or another.
- If you are an inmate, we may release your information for your health or safety in the correctional facility; We may share your information with appropriate military entities if you are a member or veteran of the armed forces; We may be required to disclose information for national security or intelligence purposes.

With your Authorization: Other uses and disclosures will be made only with your written authorization. For example, we will ask for your written permission before promoting a product or service to you for which we will be paid by a company, and generally before sharing your health information in a way that is considered a sale under the law. If you sign an authorization, you may revoke it at any time, except where we have already shared your information based upon your permission.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to access, inspect and copy your protected health information.

- This usually includes medical and/or billing records. You must submit a written request to us, and you agree to pay the reasonable costs associated with complying with your request before we provide you with your record
- You may ask us to provide your electronic record in electronic format. If we are unable to do provide your record in the format you request, we will provide the record in a form that works for you and our office. You may ask us to transmit your record to a specific person or entity by making a written, signed request. *[If your practice uses unencrypted email add: You may request the information be sent via our email system if you sign a statement that you understand that email comes with inherent risks for which our office is not responsible.]*
- Under certain circumstances, your provider may not allow you to see or access certain parts of your record. You may ask that this decision be reviewed by another licensed professional.

You have the right to request to receive confidential communications, and request contact from us by **alternative means** or at an alternative location.

You have the right to request a restriction of your protected health information.

- This means you may ask us not to use or disclose all or part of your protected health information for certain purposes. We will consider your request carefully, and may

honor reasonable requests where possible. The law does not require us to agree to every request.

- However, if you wish to restrict certain sensitive or other health information from your insurer after you or your personal representative have paid out of pocket in full for your services, please discuss this request with us. We will honor your request where we are not required by law to make the disclosure. *[If applicable: You will need to make a new restriction request at each office visit.]* If your insurance plan "bundles" your services together so that we cannot withhold only one item or service from your claim, we will discuss your options with you.
- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to receive an accounting of certain disclosures we have made of your protected health information. Please speak with us if you have this request.

You may have the right to request amendment of your protected health information. While we cannot erase your record, we may add your written statement to your protected health information to correct or clarify the record where your provider approves. If the provider disapproves, you may submit a statement of disagreement and we may submit a rebuttal, which will remain with your record.

Fundraising. *We do not currently conduct fundraising campaigns.* You have the right to opt-out of any fundraising solicitation or communication.

Breach notification. We are required to have safeguards in place that protect your health information. In the event that there is a breach of those protections, we will notify you, the U.S. Department of Health and Human Services and others, as the law requires.

You may file a complaint with us by notifying our office with your written complaint. We will not retaliate against you for filing a complaint with us or the Office of Civil Rights.

You may complain to the Office of Civil Rights at the Department of Health and Human Services (OCR) if you believe your privacy rights have been violated by us. You should contact the OCR in writing at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Wayne R. Nelson DC/Condition For Life
335 So. Spring Street, Klamath Falls, OR 97601

Please sign below and return this form to the receptionist so that we know you have received our Notice of Privacy Practices.

I acknowledge receipt of the Notice of Privacy Practices prepared by *Condition For Life*. Also, I acknowledge that I have had an opportunity to ask questions about the practice's Notice of Privacy Practices.

Furthermore, I give my permission (until revoked) to discuss my case with the following people:

Name	Revoked (date)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name of Patient or Legal Guardian (please print) _____

Signature _____

Date: _____