WESTERN WAKE WELLNESS, PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU REQUIRE MORE INFORMATION, PLEASE CONTACT OUR HIPAA COMPLIANCE OFFICER AT THE CONTACT INFORMATION AT THE END OF THIS NOTICE.

At WWW we understand that your medical information about you and your health is personal. Our practice is committed to protecting your medical information. We are required by federal and state laws to maintain the privacy of your Protected Health Information **(PHI)** and to give you this notice explaining our privacy practices with regard to that information. This notice explains your rights and our legal obligations regarding the privacy of your **PHI**. Protected Health Information is information that individually identifies you. It may be used and disclosed by your physician, our office staff, another health care provider, your health plan, your employer, or a healthcare clearing house that relates to (1) your past, present, or future physical conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information.

For your Treatment: Your **PHI** may be provided to a physician or healthcare provider (a specialist or laboratory) to whom you have been referred, to ensure they have the necessary information to diagnose, treat or provide you a service.

For Payment: Your **PHI** may be used and disclosed to enable us to bill and either collect payment from you, a health plan or a third party for the treatment and services you receive from us. As an example, we may need to give your health plan information of your treatment in order for your health plan to agree payment for that treatment.

For Health Care Operations: We may use and disclose your **PHI** in order to support the business activities of your physician's office. These activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to physicians, nurses, medical technicians, medical students and other authorized personnel for educational and learning purposes. We participate in Organized Health Care Arrangements with providers in the UNC Health Alliance and the UNC Senior Alliance. We may use your PHI for our own health care operations and for those of the Organized Health Care Arrangements in which we participate.

Appointment Reminders/Treatment Alternatives/ Health-Related and Services: We may use and disclose your **PHI** to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.

As required by Law: We will disclose your **PHI** about you when required to do so by international, federal, state, or local law.

Marketing & any purposes which require the sale of your information: These disclosures require your written authorization.

Any other uses and Disclosures not recorded in this Notice will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your **PHI**, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.

The Right to Inspect and Copy: Under federal law you have the right to inspect and copy you **PHI** (we have up to 30 days to make your **PHI** available to you, fees may apply). You have a right to a Summary of your **PHI** instead of the entire record, or an explanation of the **PHI** which has been provided to you so long as you agree to this alternative form and agree to pay the associated fees.

The Right to an Electronic Copy of Electronic Medical Records: You have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your medical records, if they are maintained in an electronic format. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fees may apply).

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The Right to Request Restrictions: You have the right to request a restriction or limitation on the **PHI** we use or disclose for treatment, payment, or health care operations. You may ask us not to use or disclose any part of your **PHI** and by law we must comply when the **PHI** pertains solely to a health care item or service which the health care provider involved has been paid out of pocket in full. You also have the right to request a limit on the **PHI** we disclose about you to someone involved in your care or payment of your care. Your request must be made in writing to our HIPAA Compliance Officer with specific instructions. If we agree to the restriction, we may only be in violation of that restriction for emergency treatment purposes. By law, you may not request that we restrict the disclosure of your **PHI** for treatment purposes.

The Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured **PHI**.

The Right to Request Amendments: If you feel that the **PHI** we have is incorrect or in complete, you may ask us to amend the information. A request and the reason for the requested amendment must be made in writing to the HIPAA Compliance Officer at the information at the end of this Notice. In certain cases we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy.

The Right to an Accounting of Disclosures: You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred six years prior to the date of request. Your request must be made in writing and you must indicate in what form you want the list, for example on paper or electronically. The first accounting of disclosures in any 12-month period will be free. Any additional requests within that same time period we may charge reasonable costs. You may withdraw or modify your request before the costs are incurred.

The Right to Request to Receive Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

Complaints: You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us you must make it in writing to our HIPAA Compliance Officer at the information at the end of this Notice. Complaints must be submitted within 180 days of when you knew of or suspected the violation. **There will be no retaliation against you for filing a complaint.**

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W. Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hippa/ for more information. **There will be no retaliation against you for filing a complaint.**

If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer, Melissa Sangster, in person or by phone at the bottom of this form. You have the right to request a paper copy of this Notice at any time even if you have agreed to receive this Notice electronically. A copy of this Notice may also be found on our website Please sign below to acknowledge you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

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Print Name of Patient/Responsible Party **Signed** **Date**