HIPPA Consent/Authorization

for use and disclosure of protected health information

OUR PRIVACY PLEDGE: We are concerned with and committed to the protection of our clients' privacy and ensuring the confidentiality of personal health information entrusted to us.

Ways in which we may use or disclose your health care information include, but are not limited to:

- To another provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as an insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
- The use of that information within our practice for quality control of other operational purposes.
- Business associates with whom we contract to perform and bill for a service for your benefit.
- The use of that information to contact you by telephone, mail or e-mail, with appointment reminders, information about our facilities, treatment alternatives, or other health-related information that may be of interest to you.

Along with that consent form, you will be given a copy of our privacy notice that describes our privacy policy in full detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be posted in our facility, and will also be given to you when you come in for treatment.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosures of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

You have a right to refuse consent for disclosure of your personal health information.
Without your consent, however, we will not be able to submit claims to insurance carriers or other third party payers and may not accept you as a client.

I acknowledge receipt of this Notice of Privacy Practices. initial here: _____

By signing below, I give consent to disclose my personal health information.

_____
client name

_____
signature

_____
date

_____
Be Wellness LLC

_____
signature

_____
date

HIPPA - Client Copy
Notice of Privacy Practices

This notice describes how your personal health information may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR PRIVACY PLEDGE: Our facility is committed to full compliance with federal and state laws and regulations ensuring that privacy and confidentiality of our clients' personal health information; the therapists and staff will make every effort to respect your privacy and keep confidential the health information entrusted to us.

Our Duties: We are required by law to maintain the privacy of your health information, to provide you with this notice of our legal duties and our privacy practices, and to abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices in accordance with federal and state law; any such change will apply for all of your health information in our files. Clients will be asked to consent to the use or disclosure of your protected health information by agreeing to allow the massage therapists and staff members to:

- Disclose your health information to another health care provider or facility for the purpose of diagnosis, assessment or treatment of your condition.
- Disclose your examination, treatment and billing records to another party, such as an insurance carrier, an HMO or your employer for the purpose of receiving payment of services rendered to you.
- Use your health information, examination, treatment and billing records for quality control or other administrative purposes to efficiently and effectively operate the practice.
- Disclose your health information to business associates that perform services for your benefit and bill for it. All business associates are contractually required by us to similarly safeguard the privacy and confidentiality of any personal health information disclosed to them.
- Use your personal health information to contact you by telephone, mail or email with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you.

Required or Permitted Uses and Disclosures Without Your Consent: Use or disclosure of your health information without your consent may be required or permitted in some circumstances, including but not limited to:

1. The extent that we are required or permitted to do so by applicable federal or state laws;
2. A public health authority for a wide range of public health activities when authorized to collect or receive your health information under federal and state law;
3. An appropriate government authority if there is reason to believe you are the victim of abuse, neglect or domestic violence;
4. Federal or state health care system and government benefit program oversight activities;
5. A response to a court order, in response to a subpoena, discovery request or other lawful purpose;
6. Law enforcement officials when required to report certain types of wounds or physical injuries, or to comply with court orders, a grand jury subpoena or administrative requests;
7. An appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the person or the public;
8. A correctional institution if we provide health care services to you as an inmate;
9. Emergent care situations; and
10. Providing care to you that is related to a work-place injury to the extent necessary to comply with Minnesota's worker's compensation laws.

HIPPA - Client Copy
Notice of Privacy Practices

continued

The Health Care Information Rights of Our Clients Include:

Your Right to Revoke Consent: You may revoke your consent to use or disclose your health information at any time; however, your revocation must be in writing; there are two circumstances under which we will not be able to honor your revocation request: 1) Your health information was released prior to receipt of your request to revoke your consent; and 2) Where you are required to give your authorization as a condition for obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Your Right to Limit Uses or Disclosures: You have a right to limit the use or disclosures of your personal health information. To do so you must inform us, in writing, of any health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may choose to drop your request or to seek care from another health care provider or facility.

Your Right to Receive Confidential Communications Regarding Your Health Information: We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about status of your account. We will do our best to accommodate any reasonable, written request if you would like to receive information about your health or the services that we provide at a place other than your home or if you would like the information in a different form.

Your Right to Inspect and Copy Your Health Information: You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files; such requests must be in writing. We may refuse your request, and charge you for retrieval and copying costs, only in accordance with Minnesota law.

Your Right to Amend Your Health Information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. Amendment requests must be in writing and give us reason to support the change you are asking us to make; however we are not obligated to comply with your request if it is judged to be unreasonable.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records: You have the right to submit a written request for an accounting of the disclosures we have made of your health information for the last six years before the date of your request. Such accounting requests will include all disclosures made except for those that: 1) Are required for your treatment, to obtain payment for your services or to operate our practice; 2) Were made to you; 3) We are required or permitted to make without your consent or authorization; 4) Were disclosed with your written consent; 5) Were necessary to maintain a facility directory of individuals involved with your care; 6) Were disclosed for national security or intelligence purposes; 7) Were made to correctional or law enforcement officers; 8) Were made prior to August 11, 2008. We will provide the first accounting within any 12-month period without charge. Retrieval and copying fees complying with Minnesota law may be charged for any additional accounting requests during the same 12-month period. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right to Obtain a Paper Copy of This Notice: You may request a copy of this notice at any time.

Your Right to Complain: You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to do so and will not take any action against you if you do file a complaint.