Center for Integrative Health, LLC
Nancy H. O'Hara, MD & Gail M. Szakacs, MD
3 Hollyhock Lane Wilton, CT 06897
Tel: 203-834-2813 Fax: 203-834-2831

NOTICE OF PRIVACY PRACTICES

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

We understand that your medical and health information is personal and private. In order to provide you with quality care and to ensure compliance with certain legal requirements, we create a record of the care and services you receive in our office. We respect the privacy and confidentiality of medical and health information about you and that can be identified with you. This is called "protected health information". Your protected health information is contained in the medical and billing records maintained by this practice. It includes demographic information and information that relates to your present, past or future physical or mental health and related health care services.

Our Legal Duty:
We are required by Federal and State law to maintain the privacy of your health information which we have either created in our practice or received from another healthcare provider. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices outlined in this notice while it remains in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. If we make a significant change in our privacy practices, we will revise this Notice appropriately and make the new Notice available to you. You may request a copy of our notice at any time.

Uses and Disclosures of Health Information:
Treatment: How we may use and disclose your health information to a physician or other healthcare provider for treatment or payment. For example, our health care providers may disclose information about your health condition to your referring physician, a pharmacist who needs the information to dispense your prescription, or a laboratory that requires it to perform testing.
Insurance: We may inform your insurance company about a treatment that we intended to provide so that we may obtain the appropriate approvals. All medical records required by your insurance company for payment will be sent to you first.

Health Care Operations:
We may use and disclose your protected health information:

- To review and improve the quality of care you receive;

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- To our accountants who are auditing our billing records;
- In order to compare your information with that of several other patients to determine if we should offer new services or if new treatments were effective;
- To identify groups of patients who have similar health problems to give them information about treatment alternatives, programs or new procedures;
- To organizations that assess the quality of care we provide to our patients (such as government agencies or accrediting bodies)

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by you while it was in effect. Unless you give written authorization we cannot use or disclose your health information for any reason except those outlined in this Notice or as otherwise permitted by HIPAA regulations.

Required By Law: We may use or disclose your health information when we are required to do so by law.

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

Voice Messages: We may use or disclose your health information to provide you with appointment reminders or other medical treatment information on your voice mail or by mail or e-mail.

To Your Family and Friends: We must disclose health information to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care.

Patient Rights:

Access: You must make a request in writing to obtain access to your health information. Under current state law, we may charge you no more than 0.45 cents per page if we make a copy/copies of your medical records. If you request an alternate format, we will charge you a cost-based fee for providing your health information in that format. If you prefer we will prepare a summary or an explanation of your health information for a fee.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these

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additional restrictions but if we do, we will abide by our agreement except in the case of an emergency.

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

Amendment: You have the right to request that we amend your health information. *Your request must be in writing,* and it must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints:

If you want more information or have questions or concerns, please contact us. Center for Integrative Health, 3 Hollyhock Lane, Wilton, CT 06897 203-834-2813

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information to have us communicate with you by alternate means or locations, you may complain to us using the contact information listed within this notice or you may submit a written complaint to the U.S. Department of Health and Human Services. You will not be penalized or retaliated against in any way for making a complaint to the U.S. Department of HHS or to this physicians office.

We support your right to the privacy of your health information.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to treatment.

I,_____, have received a copy of Center for Integrative Health, LLC Notice of Privacy Practices describing how medical and health information about me may be used and disclosed. I understand that if I have questions or complaints I may contact the office at (203) 834-2813 and speak with the privacy contact.

_____

Patient Name

_____

Your signature

_____

Relationship to Patient

_____

Date