Nourishing Medicine, LLC
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P.O. Box 173 Fax (630)566-1633
Big Rock, IL 60511

HIPAA Notice

Name:_____ Date of Birth:_____

Notice of Privacy Practices

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

Our Responsibilities Under HIPAA

In the course of providing health care we generate, collect and share health related information pertaining to our patients. Traditionally that information was kept confidential by ethical traditions and a patchwork of regulations that vary by state. We have certain responsibilities regarding that information due to Congressional enactment of HIPAA, the Health Insurance Portability and Accountability Act. Under HIPAA, all information in your medical record along with associated billing and payments plus other related demographic data which can be traced back to you as an individual is considered PHI (Protected health information). This notice explains how we use and disclose medical information about you and inform you of your rights to access and control that information..

Protected Health Information Uses and Disclosures

The following are examples of the types of uses and disclosures of your PHI that might occur. Some are more likely to happen than others, some may not ever happen. These examples are neither exhaustive nor an indication of what we intend to do. They are simply examples of the types of uses and disclosures that could be made by our medical practice without your permission as allowed by HIPAA.

- Medical Treatment
- Payment
- Health Care Operations
- Appointment and Patient Reminders
- Emergency Situations
- Research, Death and Organ Donation
- Required by Law
- To Avert Serious Threat to Health or Safety
- Workers Compensation
- Oversight of Health and Public Policy
- Investigative, Government and Security Activities
- Lawsuits and Disputes
- Law Enforcement and Criminal Activity

Changes to this Notice – We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, top-center the date of the last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

Complaints – If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Compliance Officer who will direct you on how to file an official complaint. All complaints must be submitted in writing and all complaints shall be investigated without repercussion to you. You will not be penalized for filing a complaint.

Disclosures and Uses of PHI with your written Permission – We will not disclose your PHI for any purpose not previously referenced in this notice without first obtaining your written authorization. When we need your permission, you may grant it by signing an authorization form. You may later revoke it in writing, except to the extent an action, use or disclosure was already performed as a result of you prior authorization.

Business Associates – Companies who provide services to our practice who may have access to our patient's PHI will be required to sign a Business Associate Agreement protecting the practice from PHI disclosures without authorization. An example of a business associate would be a medical transcription service.

Your Rights As Our Patient

Access to Your Health Information – You have the right to inspect and obtain copies of your PHI that may be used to make decisions related to our care for you, generally within 30 days. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your PHI, you must submit your request in writing to our Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying and mailing.

We may deny your request to access and disclose in certain very limited circumstances, such as when disclosure would reasonably endanger you or another person. If you are denied access to medical information, you may request the denial be reviewed.

Right to Amend – If you feel the medical information we have about you in your records is incorrect or incomplete, you may ask us to amend the information. Your right to request an amendment will be for as long as the practice maintains your medical record.

To request an amendment, your request must be submitted in writing to the Compliance Officer, along with your intended amendment with a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. If we believe that the PHI is already accurate and complete, we will deny your request. We will likely deny requests for amendment to any PHI that was not created by us (unless you provide reasonable evidence that the person or entity that created the information is no longer available to make the amendment). We cannot grant requests to amend PHI, which is not dept by the practice or which is not part of the PHI that you are permitted to inspect.

As part of your access right, you have the right to authorize and later revoke in writing the use or disclosure of your PHI to anyone for any purpose with limited exceptions. (See above section entitled Disclosures and Uses of PHI with your Written Permission).

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you to others.

To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back. We will notify you of any cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions – You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received. Your request must be made in writing and (1) state what information is to be limited (2) to whom the restriction applies and (3) if the restriction applies to use, disclosure or both.

We are not required to agree to these additional restrictions, but if we do, we will comply with your request except in cases of emergency or when we are otherwise required to disclose the information by law.

Right to Request Confidential Communications – You have the right to request that we communicate with you about medical matters in a certain way or at a certain time. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail messages, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to a Paper Copy of this Notice – You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

THE NAME OF OUR COMPLIANCE OFFICER MAY BE OBTAINED FROM THE RECEPTIONIST AT OUR OFFICE.

Signature: _____ Date: _____

Print Name: _____