MEDERI CENTER

Wholistic Health and Healing
Patient Care | Research | Education

## YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your protected health information (PHI). Under this law your health care providers generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibilities to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your optimal health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly, but we will never share confidential details of your case with another provider without first asking for and obtaining your consent.
- With your family, friends, relatives, or others who are involved in your health care or health care bills unless you indicate otherwise (use the restriction field below).
- To protect the public's health, such as reporting when a communicable disease is in your area.
- To make required reports to the police, such as in instances of abuse.
- To obtain payment from third party payers, such as insurance companies.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. We Please check all that apply:

☐ Please do not phone me at home. Use this alternate phone number: _____

☐ Please do not phone me at work. Use this alternate phone number: _____

☐ Please do not leave messages on my answering machine.

☐ Please do not contact me by email.

☐ Please send mail, including my bills, to this alternate address:
_____

☐ Please indicate any **restriction of your PHI** you would like us to implement:

_____

☐ Other request (please describe): _____

** Our practitioners and staff may at times communicate health information with you via email.

*** A complete copy of our HIPAA Notice of Privacy Practices is available at the front desk. You may request a copy.

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

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