RESTORATION
NATURAL MEDICINE

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used.

As required by "HIPPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

The following circumstances may require us to use or disclose your health information:

- To public health authorities and health oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to a court administrative order.
- If required to do so by a law enforcement official.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
- If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security activities authorized by law.
- To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
- For Workers Compensation and similar programs.

Our Uses and Disclosures

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Choices

- You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
- You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have a right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the

involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

- You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to:
  Restoration Natural Medicine
  drtaylorpronozuk@gmail.com
- Note: We must respond to this request within 30 days.
- You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, you request must be made in writing and submitted to Restoration Natural Medicine. You must provide us with a reason that supports your request for amendment.
- Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.
- You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.

Our Responsibilities
We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information and to let you know promptly if a breach occurs that may compromise the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not share your information other than described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time, but please let us know in writing if you change your mind.

Change to the Terms of the Notice
This notice is effective as of 1/1/2019 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will upload, and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. To file a complaint with our office, please contact Restoration Natural Medicine. All complaints must be done in writing. We will not retaliate against you for filing a complaint.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

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

I _____ (legal name), hereby acknowledge that Restoration Natural Medicine has provided me a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information.

_____ _____

Signature of Patient/Legal Guardian *Date*

_____ _____

Print Patient Name (required) *Print Legal Guardian Name (if necessary)*