FUNCTIONAL MEDICINE CENTER OF FORT COLLINS
NOTICE OF PRIVACY PRACTICE

This office is required to notify you writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation and how you may obtain access to that information. In addition we are providing you with a list of potential circumstances under which by law, or in accordance with our office policy, we **may** disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this 'Notice' please sign the last page and return only the signature page (page 3) to our front desk receptionist.

PERMITTED DISCLOSURES

1. For treatment purposes- discussion with other health care providers involved in your care
2. *Inadvertent disclosures- services may be rendered in an open treating area, which means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.*
3. For payment purposes - to obtain payment from any insurance company or other available collateral source, OR
4. To obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/doctor.
5. For workers compensation purposes- to process a claim or aid in investigation
6. Emergency- in the event of a medical emergency we may notify a family member
7. For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
8. To Government agencies or Law enforcement, to identify or locate a suspect, fugitive, material witness or missing person.
9. For military, national security, prisoner and government benefits purposes.
10. Deceased persons –discussion with coroners, medical examiners and family members or others who were involved in the care or payment for care of the decedent prior to death,
11. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or up coming events.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI
13. To send communications while you are being treated and we are receiving financial remuneration
14. Speaking with the patient's guardian or representative regarding bill payment
15. Providing therapy to patients in group settings
16. Right to be notified following a breach of unsecured Protected Health Information.

Any other uses of disclosures not described in the Notice of Privacy Practices will be made only after obtaining your prior written authorization.

Note: *At any time, this office may update the list of ways your PHI may be used and all updates are deemed retroactive*.

YOUR RIGHTS

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive “Detail” Privacy Notice
3. To request mailings to an address different than your residence
4. You have the right to request and receive electronic copies of your records
5. To request amendments to information, however like restrictions we are not required to agree to them
6. You have the right to receive notification in the event of a breach of unsecured PHI
7. To request restrictions on certain uses and disclosures and, however we are not required to comply with your request.
8. With advance notice of at least 14 days to the practice you may inspect your records and receive one copy of your records at no charge.
9. You have the right to request and we as a covered entity will restrict disclosure of your personal health information to a health plan if disclosure pertains to a healthcare item or service which you have personally paid out of pocket for in full.
10. You have the right to NOT receive communications regarding fund raising and none will be sent to you unless you give us written authorization

ADDITIONAL RESPONSIBILITIES OF THIS PRACTICE

1. We are required to obtain a separate signed authorization from you before your personal health information can be used in marketing and for any disclosures that constitute a sale of personal health information.
2. We are required to notify you and HHS in the event of a breach caused by any of our business associates.
3. We are responsible to look over our business associate contracts to ensure they comply with the Omnibus Rules and requirements
4. With prior authorization from you, we may contact you to send you information concerning products or services and information related or unrelated to your health.

COMPLAINTS:

If you wish to make a formal complaints about how we handle your health information please call Sarah Zahakis at (970) 282-1173. If Sarah Zahakis is unavailable, you may make an appointment with our receptionist to see her within 2 working days. If you are still not satisfied wit the manner in which this office handles your complaint, you can submit a formal complaint to:

DORA, Colorado State Regulatory Commision

REGARDING NOTICE OF YOUR RIGHT TO PRIVACY

Patient:_____ DOB: _____ Date: _____

I **understand that this** office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present. My signature below is an acknowledgement that I have received a copy of (Practice Name) Patient Privacy Notice and I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of this information to the doctor. I acknowledge that additional information published in government new letters regarding my rights is available to me upon request. I have been given the first two original pages of this 'Notice' to keep. I do not have any question regarding my rights or any of the information I have received at this time.

_____ _____

Patient signature Date

_____ _____

Witness Date

_____ _____

Print Witness Name Date