



*Bio Identical Hormone Replacement  
Achieving Hormone Balance . . . . . Naturally*

**HIPPA-Health Insurance Portability and Accountability Act**

**YOUR RIGHTS-** Under the Federal Health Insurance Portability and Accountability Act (HIPAA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

**ACCESS TO YOUR PERSONAL HEALTH INFORMATION-** You have the right to inspect and/or obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records.

**FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES-** With your written consent we may disclose to family members, close personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information without your written or verbal approval. We may also disclose your personal health information to the public or private entities to assist in disaster relief efforts.

**OTHER USES AND DISCLOSURE:** We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For public health activities (reporting of disease, injury, birth, death, or suspicion of child abuse, neglect, or domestic violence).
- To government authority if we believe an individual is a victim of abuse, neglect or domestic violence.
- For health oversight activities (for example-audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions).
- For law enforcement purposes (for example-reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons).
- To avert a serious threat to health or safety under certain circumstances.
- For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution.
- For compliance with worker's compensation claims.

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose AIDS/HIV related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

Patient:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Witness:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date