

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This HIPAA Notice of Privacy Practices (the “**Notice**”) contains important information regarding your medical information. You also have the right to receive a paper copy of this Notice and may ask us to give you a copy of this Notice at any time. If you received this Notice electronically, you are entitled to a paper copy of this Notice. If you have any questions about this Notice please contact the person listed in Part 8, below.

The Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”) imposes numerous requirements on employer health plans regarding how certain individually identifiable health information – known as protected health information (“**PHI**”) – may be used and disclosed. This Notice also describes your rights to access and control your PHI. PHI is information which may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you and will use it to the minimum extent necessary to accomplish the intended purpose of the use, disclosure, or request of it. This Notice applies to all of the medical records we maintain.

Your personal doctor or health care provider may have different policies or notices regarding their use and disclosure of your medical information.

We are required by law to abide by the terms of this Notice to:

- Make sure that medical information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you
- Follow the terms of the Notice that is currently in effect.

How We May Use And Disclose Medical Information About You. **HIPAA** generally permits the use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. These uses and disclosures are more fully described below. Please note that this Notice does not list every use or disclosure, instead it gives examples of the most common uses and disclosures.

- **Treatment:** When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to health care providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you. Additionally, we may share medical information about you in order to coordinate your care for such reasons as prescriptions, lab work, and x-rays.
- **Health Care Operations:** When and as appropriate, we may use and disclose medical information about you for our operations, as needed. For example, we may use medical information in connection with: conducting quality assessment and administration improvement; case management; coordination of care; business planning; customer service; and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our patients receive quality care. We may also combine PHI about many of our patients to decide what additional services we should offer, what services are not needed, and whether certain treatments are effective. We review our treatment and services in order to evaluate the performance of the dietitian who is providing your services. We may also

disclose information to doctors, nurses, technicians, medical students, and other personnel of AMS Nutrition Counseling, PLLC for review and learning purposes.

OTHER PERMITTED USES AND DISCLOSURES

- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness. Additionally, we may disclose health care information where your employer has a duty under state or federal law, to keep records or act on such information.
- **To Comply with Federal and State Requirements:** We will disclose medical information about you when required to do so by federal, state, or local law. We may disclose your medical information to a health oversight agency for activities authorized by law (such as audits, investigations, inspections, and licensure).
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information. We may permit researchers to review records to help identify patients who may be included in their research projects or for similar purposes as long as the researchers do not remove or take a copy of any health information.
- **Judicial and Administrative Proceedings:** We may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.
- **Public Health:** As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- **Law Enforcement:** We may release PHI as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. We may also disclose PHI in response to a request related to identification or location of an individual, a victim of crime, a decedent, or a crime on the premises.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Food and Drug Administration (FDA):** We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products, and product defects, or postmarketing surveillance information to enable product recalls, repairs, or replacement.
- **Business Associates:** We may disclose your medical information to our business associates. We have contracted with entities (defined as "business associates" under HIPAA) to help us administer services to our patients. We will enter into contracts with these entities requiring them to only use and disclose your health information as we are permitted to do so under HIPAA.

- **Fundraising:** We may also contact you as part of fundraising efforts. You have the right to opt out of receiving such communications.
- **Other Uses:** If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. We may release your medical information to a coroner or medical examiner. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your information to the correctional institution or law enforcement official.

Uses and disclosures other than those described in this Notice will require your written authorization.

Your written authorization is required for: most uses and disclosures of psychotherapy notes; uses and disclosures of PHI for marketing purposes; and disclosures that are a sale of PHI. **You may revoke your authorization at any time to the extent that we have not already taken action in reliance on your previous authorization.**

Your Rights Regarding Medical Information About You. You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your care or payment for your care, including PHI stored electronically. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. In addition, you must provide a reason that supports your request.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:
 - Information that is not part of the medical information kept by or for our records.
 - Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
 - Information that is not part of the information which you would be permitted to inspect and copy.
 - Information that we believe is accurate and complete.
- **Your Right to an Accounting of Disclosures:** You have the right to request an “accounting of disclosures” (that is, a list of certain disclosures we have made of your PHI). Generally, you may receive an accounting of disclosures if the disclosure is required by law, made in connection with public health activities, or in similar situations as those listed above as “Other permitted uses and disclosures.” You do not have a right to an accounting of disclosures where such disclosure was made:
 - For treatment, payment, or health care operations.
 - To you about your own health information.
 - Incidental to other permitted disclosures.
 - Where authorization was provided.
 - To family or friends involved in your care (where disclosure is permitted without authorization).
 - For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
 - As part of a limited data set where the information disclosed excludes identifying information.

To request this list or accounting of disclosures, you must submit your request, which shall state a time period, which may not be longer than six years. Your request should indicate in what form you want the

list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Your 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, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. If we do agree to a request, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is required by the Secretary of the Department of Health and Human Services, or the disclosure is required by law.

To request restrictions, you must make your request in writing and must tell us the following information:

- What information you want to limit.
 - Whether you want to limit our use, disclosure, or both.
 - To whom you want the limits to apply (for example, disclosures to your spouse).
- **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 location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how and/or where you wish to be contacted.
 - **Right to a Paper Copy of this Notice:** You have a right to receive a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We encourage you to read and ask questions about this Notice.
 - **Right to Receive Notice of Breach:** You have a right to be notified upon a breach of any of your unsecured PHI.
 - **Rights for Out-of-Pocket Payments:** If you paid out-of-pocket, in full, for a specific item or service, you have a right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. We are required to agree to your request unless the disclosure is otherwise required by law.

You must make any of the requests described above, to the person listed in Part 8, below.

1. **Breach Notification.** We understand that medical information about you and your health is personal and we are committed to protecting your medical information. Furthermore, we will notify you following the discovery of any “breach” of your unsecured PHI as defined in the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, “**the HITECH Act**”) (the “**Notice of Breach**”). Your Notice of Breach will be in writing and provided via first-class mail, or alternatively, by e-mail if you have previously agreed to receive such notices electronically.

2. **Changes To This Notice.** We can change the terms of this Notice at any time. If we do, the new terms and policies will be effective for all of the medical information we already have about you as well as any information we receive in the future. We will send you a copy of the revised notice.

3. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with AMS Nutrition Counseling, PLLC or with the Secretary of the Department of Health and Human Services. To file a complaint with AMS Nutrition Counseling, PLLC, contact the person listed in Part 8, below. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

4. Other Uses Of Medical Information. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you grant us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we may be required to retain our records related to your benefit determinations and enrollment.

5. Effective Date. The effective date of this Notice is January 1, 2017.

6. Contact Information. All correspondence relating to the contents of this Notice should be directed as follows:

AMS Nutrition Counseling, PLLC
Attn: Amy Shults
64 Davison Court
Lockport, NY 14904

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I acknowledge that I have received the HIPAA Notice of Privacy Practices (the “**Notice**”) from AMS Nutrition Counseling, PLLC (“**AMS**”) and that I have been provided an opportunity to review it. I understand that:

- I have certain rights to privacy regarding my protected health information.
- AMS can and will use my health information for purposes of my treatment, payment for treatment and health care operations.
- The Notice explains in more detail how AMS may use and share my protected health information for other purposes.
- I have the rights regarding my protected health information listed in the Notice.
- AMS has the right to change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

Name: _____ Date: _____

Signature: _____ Date of Birth: _____

Relationship to Patient (if applicable): _____

POLICIES AND CONSENT TO TREAT

Below you will find detailed information regarding your rights and responsibilities and established policies of AMS Nutrition Counseling, PLLC's practice. Please read this carefully and sign at the end of each section if you agree. Please feel free to ask any questions for clarification:

Consent to Treatment:

I have read through all the information provided to me and have been clearly advised of my rights and responsibilities as a client of AMS Nutrition Counseling, PLLC, including the HIPAA Notice of Privacy Practices.

I understand these rights and responsibilities and agree to abide by them. I consent to treatment, and I understand I have a right to receive a copy of this form upon request. I also understand that I can withdraw this consent in writing and terminate at any time.

Signature: _____

Date: _____

Signature on File Authorization:

By signing this statement, you are authorizing AMS Nutrition Counseling, PLLC to complete any necessary insurance claim forms on your behalf. You are also authorizing the release of any medical or other information which may be needed in order to process your claims. Your signature will be kept on file and shall be referred to when insurance claim forms are submitted for healthcare services you have received. **Note:** if you are incapable of signing, or are under the age of 18, a parent or legal guardian must sign in your place.

Signature: _____

Date: _____

Date of birth: _____

Insurance card ID number: _____