HIPPA CONSENT FORM- NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests 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. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment, including direct or indirect treatment by other healthcare providers involved in my treatment.
- Payment including obtaining reimbursement for services, billing, or collections activities.
- The day-to-day healthcare operations and scheduling of Med Boutique including confirming appointments.
- Med Boutique may disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to ensure its continued confidentiality.
- Med Boutique may leave a detailed message on voicemail, text, or email or any other form of contact.
- Med Boutique acknowledges that if yoi have paid for services “out of pocket”, in full, and you request that we do not disclose your PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.
- We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
- We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

I understand that Med Boutique reserves the right to change the terms of this notice from time-to-time and that I may contact Med Boutique at any time to obtain the current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment and healthcare operations. Med Boutique is not required to agree to these requested restrictions. If Med Boutique does agree to them, Med Boutique is bound to comply with requested restrictions.

I understand that I may revoke this consent, in writing, at any time and Med Boutique is required to honor and abide by that written request. However, any use or disclosure that occurred prior to the date I revoke is not affected.

I am a patient of Med Boutique. I hereby acknowledge receipt of Med Boutique’s Notice of Privacy Practices.

By signing below, I acknowledge and understand that this information will be kept in my medical record. It is my responsibility to notify Med Boutique should I change one or more of the following: telephone number, email address, mailing address.

Client Signature: _____ Date:_____