NOTICE OF PRIVACY PRACTICES

This summary describes how we use and share information about you.
This summary describes how you may see and get copies of this information.

WE MIGHT USE OR SHARE INFORMATION ABOUT YOU FOR.

Treatment: Such as when our providers, nurses and medical assistants discuss your care or provide copies of your medical record to another healthcare provider for continuation of care.

Payment: Such as when we bill your insurance company for services provided to you.

Other ways: Such as when we send disease reports to county and state health offices as required by law
When we provide information to funeral directors, organ donation groups and researchers.
When we share information to protect the health and safety of others or you.

HOW YOU MAY SEE AND GET COPIES OF THIS INFORMATION

You have the right to:

- Ask for restrictions on the ways we use and give out your information. However, we are not required to do as you ask.
- Get and inspect a copy of your medical record.
- Add information to your medical record.
- Ask that your health information be sent to a different address or that we call you at a different phone number
- Change your mind if you told us we could use or share your information for reasons other than those listed above.
- Get a list of the times we gave out your information. It will be a list of the times that the law requires us to keep a record of giving out your information.

OUR COMMITMENT TO RESPECT PRIVACY

We are required to:

- Keep your information confidential.
- Let you know is we cannot do what you have asked us to do with your information.
- Try to reach you at another location or phone number if you ask us to do so.
- Use and/or give out your information as listed above and as the law permits, unless we have your permission to do more.

As we serve our patients we may change what we do with your information to comply with the federal regulations. If we make a change we will inform you the next time you visit us for care. You may call or write us to check if we have made any changes.

If at any time you feel that your privacy rights have been violated you may file a complaint with us. You will not be mistreated for filing a complaint.

Healing Gardens Health Center
315 Canyon Avenue, Suite 1
Fort Collins, CO 80521

_____ _____
Name of Patient (please print) **Date of Birth**

I hereby acknowledge that I received Healing Gardens Health Center's Notice of Privacy Practices.

_____ _____
Signature of patient or patient representative Date

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:
_____
_____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity

☐ Other reason (describe below)
_____
_____

_____ _____
Signature of Employee Completing Form Date