**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

Respect for patient privacy is highly valued at my practice. As required by law, I will protect the privacy of your health information that may reveal your identity and provide you with a copy of this notice, which describes the health information privacy procedures of my practice.

**REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

I will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct the clinic operations. This general written consent will be obtained the first time I provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time I provide treatment or services to you.

**HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION**

**USES AND DISCLOSURES**

I use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

**YOUR RIGHTS**

In most cases, you have the right to look at or get a copy of health information about you. You also have the right to receive a list of certain types of disclosures of your information that I have made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

**MY LEGAL DUTY**

I am required by law to protect the privacy of your information, provide this notice about my information practices, follow the information practices that are described in this notice and seek your acknowledgement of receipt of this notice.

**COMPLAINTS**

If you are concerned that I have violated your privacy rights, or you disagree with a decision that I made about access to your records, you may contact me or send a written complaint to the U.S. Department of Health and Human Service.

**LIGHTSTONE ACUPUNCTURE**

**Notice of Privacy Practice**

**ACKNOWLEDGEMENT AND CONSENT**

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been notified of how health information about me may be used and disclosed by Lightstone Acupuncture listed at the beginning of this notice and how I may obtain access to and control of this information.

By signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me and for the operations of the office.

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Signature of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

If you have any questions about this notice or would like further information, please contact me.

For Office use only: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

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