# HIPAA Compliance Document-Concerning Your Protected Health Information

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

**The covered entity is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal and privacy practices with respect to protected health information;**

For purposes of this notice, the term "covered entity" refers to Wealth of Health Center Dr. Paula Koger

Dear Patient: You have rights concerning your private health information, your access to this information and to know how this information is used by our office. You also have rights related to our ability to contact you concerning your activity in our practice, such as recall reminders, billing, and other matters related to how we communicate with you and others on your behalf. Please understand that this office and each and all of its employees and associates make every effort possible to keep confidential your private medical information at all times and with your consent only, will such information ever be shared with others.

A. The covered entity may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

B. Your information will not be shared with any third party without your express written consent.

C. Your records are available to you for your review, copying or corrections by appointment and you will not be denied access to your personal health information. Any changes you request to your personal health information must be supplied to this office in writing and you will be advised within 30 days of any objection to the correction, or that the correction has been made.

D. With respect to other providers requesting your personal health information, we will require a **written authorization for the release of medical records signed by you**, detailing the name, address and phone number of the requesting physician or facility. Under no circumstance will we discuss your personal health information with anyone without your express permission in writing. (This will of course exclude any office staff that has necessary access to your record)

**I have received a copy of this Privacy Notice**

Patient Signature________________________________________ Date___________________

Print Your Name ________________________________________