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 REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires 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, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes; treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be an occupational therapy evaluation.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosers will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

YOUR RIGHTS
You have the following rights with respect to your protected health information, which you can exercise by providing a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend you protected health information.
- The right to receive an accounting of disclosures of prtotected health information.
- The right to obtain a paper copy of this notice from us upon request.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with
ADVANCE THERAPY or with the Secretary of the Department of Health and Human Services. To file a complaint with ADVANCE THERAPY, contact Jennifer Jensen at ADVANCE THERAPY 6776 Lake Drive #220, Lino Lakes, Minnesota 55014, phone: 651-784-7007, fax: 651-784-7992. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE
We request that you sign below acknowledging you were offered a copy of this notice. This acknowledgement will be filed with your records.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have read the Notice of Privacy Practices from ADVANCE THERAPY and was offered a copy.

X_____ **Date:** _____
Signature