

## NOTICE OF PRIVACY PRACTICE

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15-3039 Pahoia Village Rd.  
Pahoia, HI 96778

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 office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected Health Information (referred to as “PHI”) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

### Examples of uses and disclosures of your PHI

- 1. For treatment purposes:** During the course of your treatment, the physician might share your PHI with a specialist to coordinate the best care for you.
- 2. For Payment purposes:** We may submit requests for payment to your insurance company.
- 2. Communication with family:** Using our best judgement, we may disclose to a family member, other relative, close personal friend, or any other person you identify, PHI relevant to that person’s involvement in your care or in payment for such care if you do not object or in an emergency.
- 3. Notification:** Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.
- 4. Disaster relief:** We may use and disclose your PHI to assist in disaster relief effort
- 5. Workers Compensation:** If you are seeking compensation through Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.
- 6. Public Health:** As authorized by law, we may disclose your PHI to public Health or legal authorities charged with preventing or controlling disease, injury, or disability: to report reactions to medications or problems with products: to notify people of recalls: to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.
- 7. Abuse and Neglect:** We may disclose your PHI to public authorities as allowed by law to report abuse or neglect.
- 8. Employers:** We may release PHI about you to your employer if we provide health care services to you at the request of you employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.
- 9. Correctional Institutions :**If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.
- 10. Law Enforcement:** We may disclose you PHI for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

**11. Health Oversight:** Federal Law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities.

**12. Judicial/Administrative Proceedings:** We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

**13. Serious Threat:** To avert serious threat to health or safety, we may disclose your PHI consistent with applicable law to prevent or lessen a serious, imminent threat to health or safety of a person or the public.

**14. For Specialized Government Functions:** We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

**15. Coroners, Medical Examiner, and Funeral Directors:** We may release PHI to a coroner or medical examiner. This may be necessary, for funeral directors as necessary for them to carry out their duties.

**16. Other Uses:** Other uses and disclosures, besides those identified in this “Notice”, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided under “Your health information rights”.

### Client Rights under HIPAA

Under HIPAA, clients are entitled to more information about and more control over their own health information. The health and billing records we maintain are the physical property of this office. The information in it, however, belongs to you. Your client rights are:

#### **1. The Right to Receive a Notice of Privacy Practices (NPP):**

HIPAA requires Vitality Integrative Medicine (VIM) to provide each client a NPP upon client request, at or prior to the first provision of care. An acknowledgement of providing the NPP to the client is recorded in client file. Any person, whether or not they are an VIM client, who asks for a copy of VIM’s NPP must be provided a paper copy.

#### **2. The Right to Access Protected Health Information (PHI).**

Under HIPAA, clients have a right to examine and, if they wish, to receive a copy (electronic or paper) of, all the health information VIM has on a client that we use to make decisions about them. This right extends to both medical and billing records. We strongly recommend that they do this with a healthcare professional present so they can answer any questions the client may have. VIM will provide the client with access to the record within 30 days of the request. If a client would like a copy of their PHI, we may charge a reasonable, cost-based fee for providing this.. In some cases, access to PHI may be legitimately denied. For instance, access may be denied to psychotherapy notes, or if a health care professional believes that providing access to certain information may pose a danger to the client or to others.

#### **3. The Right to Amend PHI:**

Once a client accesses their health information, they may think that certain information is incorrect or missing. Oral requests for changes can only be accepted to correct typos, change demographic information, update insurance information, and correct billing or processing errors. All other requests for changes must be submitted in writing using a form designed for this purpose. This form and any appropriate supporting documentation should be forwarded to VIM. The client will receive a response within 60 days of submitting their request. This response will let them know if their request to amend their record has been granted or denied.

#### **4. The Right to an Accounting of Disclosures:**

A disclosure is a release of information outside of VIM. Sometimes VIM discloses health information for reasons other than treatment, payment, or health care operations, and the client has not signed or is not required to sign an authorization for the disclosure. Examples of this are public health reports, reports about victims of

abuse, neglect, or domestic violence, information used for organ tissue donations and transplantation, disclosures about decedents to coroners, medical examiners, or funeral directors, and other disclosures required by law. Under HIPAA, disclosures that are not part of treatment, payment, and /or operations and that are not authorized by the client must be tracked. If a client requests an accounting, or list, of these disclosures, VIM must provide them with one. Once a disclosure has occurred, documenting this into the system within one business day is a good practice, but this must be done within five business days. If you request an accounting of disclosures, you will fill out the form for this.

#### **5. The Right to Request a Specified Method of Communication:**

At times clients may ask that we communicate with them in special ways. These requests may involve a single service area or multiple service areas. We can only accept requests that impact a single service area. If a client makes a request that involves multiple areas, it is up to them to coordinate this with each area directly. A client may request a specific method of communication either orally or in writing.

#### **6. The Right to Request Restriction on Use and Disclosure of Health Information:**

Clients have the right to request restrictions on: a.) The use and disclosure of PHI for treatment, payment, and health care operations; b.) Disclosure of PHI to family members, friends, and other involved in their care. If a client would like to request a restriction of use and disclosure of PHI for treatment, payment, and/or health care operation (a), this request must be made in writing. You should let the client know that until a determination is made, their PHI will be used and disclosed as described in our Notice of Privacy Practices. The client will be notified in writing within 30 days whether their request has been accepted or denied. If a client requests that we not share their PHI with family, friends, or others involved in their care (b), they may do this orally. We should do our best to accommodate all reasonable requests, and should document the request and the decision to share or not share in the client's chart. A client can terminate these restrictions orally (if so, document in chart) or in writing. VIM may also terminate restrictions that we have agreed to by notifying the client in writing.

#### **7. Appeal a denial of access to your PHI, except in certain circumstances.**

##### Our Responsibilities

##### **Our office is required to:**

1. Maintain the privacy of your PHI as required by law.
2. Provide a notice as to our duties and privacy practices as to the information we collect and maintain about you.
3. Abide by the terms of this Notice.
4. Notify you if we cannot accommodate a requested restriction or request.
5. Accommodate your reasonable requests regarding methods to communicate PHI with you.
6. Obtain your written authorization to use or disclose your PHI for reasons other than those listed above and permitted under law.

Vitality Integrative Medicine Clinic reserves the right to change its privacy practices and to make new provisions effective for all protected PHI it maintains. As "Notices" are revised, you are entitled to receive a revised copy at our office.

If you have any questions or complaints, or if you do not want to provide you consent to your physician, to use your PHI for purposes of payment and /or health care operations, please submit a letter of denial to provide consent to :

Vitality Integrative Medicine Clinic, 15-3039 Pahoia Village Road, Pahoia, HI 96778

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Please sign and print your name and provide the date below to acknowledge that you have received, read, and understood our Notice of Privacy Practices, Please return it to our front office staff or mail it to:

**I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.**

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

**I, THE UNDERSIGNED, HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION, THE ELEMENTS OF MY INFORMED CONSENT, MY RIGHTS AND RESPONSIBILITIES, AND HEREBY GIVE CONSENT TO UNDERGO ALTERNATIVE AND COMPREHENSIVE TREATMENT AT HAWAII WHOLE PERSON HEALING COLLECTIVE, LLC. INFORMATION ABOUT ME AND MY RECORDS WILL BE CONFIDENTIAL. DATA WILL BE STORED SECURELY AND WILL BE MADE AVAILABLE ONLY TO THE PERSONS PARTICIPATING IN MY EVALUATION AND SUBSEQUENT TREATMENT, IF ANY, UNLESS I SPECIFICALLY GIVE PERMISSION IN WRITING UNLESS OTHERWISE REQUIRED BY LAW.**

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**Patient's or Patient Representative's Signature**

\_\_\_\_\_  
**(Date)**

\_\_\_\_\_  
**Print Patient's Name**

\_\_\_\_\_  
**(If Representative, Print Name and Relationship to Patient)**

**A signed copy of this document is to be given to Patient. Original is to be filed in Patient's medical records.**