Notice of Privacy Practices for Protected Health Information - True North Massage LLC

As a massage therapist I must collect a certain amount of personal information from you in order to safely work with you. It is extremely important that this information be collected responsibly and that it only be disclosed to other individuals under appropriate circumstances. This document details your rights and how I protect the privacy of your personal information. Other than the uses and disclosures described below, your health information will not be sold or provided to any outside marketing organization.

I reserve the right to change the terms of this privacy notice. If a change is made, it will apply for all of your health information in my files, and you will be notified in writing.

Uses and Disclosures of Your Information

1. I may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. I may need to use or disclose your information if providing services to you based on the orders (referral) of a health care provider.
3. I may have to disclose your session records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
4. I may need to use your name, address, phone number, and your records to contact you to provide appointment reminder calls, recall postcards, Welcome and Thank You cards, information about alternative therapies, or other related information that may be of interest to you. If you are unavailable to receive an appointment reminder call, a message will be left on your voicemail. You may request to receive confidential communications from me by alternative means or at an alternative location.

Your Right to Limit Uses or Disclosures

You have the right to request that I do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. I am not required to honor these requests. If I agree with your restrictions, the restriction is binding on me.

Revoking Your Authorization

You may revoke your authorization to me at any time in writing. There are two circumstances under which I will not be able to honor your revocation request:

1. If your information has been released prior to your request to revoke your authorization. 165.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your information if they decide to contest any of your claims.

Confidential Communication

I will attempt to accommodate any reasonable written request regarding your contact information that has been provided by you.

Amending Your Health Information

You have the right to request that I amend your health information for seven years from the date that the record was created or as long as the information remains in my files. I require a written request to amend

your records that includes a valid reason to support the change. I have the right to refuse your request.

Inspecting/Copying Your Health Information
You have the right to inspect the your files while in my office and/or have a copy made for you. The information is available up to seven years from the date that the record was created. Your request to inspect or obtain a copy of the file must be in writing. There will be a nominal fee to make the copy.

Accounting of Disclosures of Your Records
You have the right to request an accounting of any disclosures (not listed below) made of your information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- Required for your session, to obtain payment for services, to run my practice, and/or made to you.
- Necessary to maintain a directory of the individuals involved in your care.
- For national security, intelligence purposes, or law enforcement officers.

I will provide the first accounting within a 12-month period without any charge, but any additional requests will be charged a fee. When you make your request I will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request

Re-Disclosure
I cannot control the actions of others to whom I have released your information for further treatment. Information that I use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

Questions
I would be happy to discuss any questions or concerns you may have. As well, if you have a formal complaint to make concerning my privacy practices, you should contact me in writing. The address of my office is:
Sheila Resari
3958 NE 7th Ave
Portland, OR 97212

I will respond to your concerns promptly. If after discussing the issue with me, I am still not able to resolve your complaint or concern, you have the right to make a formal complaint:
Secretary for Health and Human Services
200 Independence Ave. SW, Room 509F, HHH Bldg.
Washington, DC 20201

This notice effective as of October 10, 2009. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

Client Signature Date

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