

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.

In the course of your care we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, your employer, managed care organization or attorney if they are or may be responsible for the payment of your services.
- Your name, address, phone number, email address, and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health information that may be of interest to you such as patient appreciation days, special events, holiday specials, birthday and thank you cards.
- If you are not available to receive an appointment reminder, a message may be left on your voicemail. We may use your cell number to send/respond to text messages.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing healthcare services to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive any treatment from us.

We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created, or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our policy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy policy may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you would like further information about our privacy policies and practices please contact:

Diane Fisher, LMT
3437 N. High Street, Suite F
Columbus, OH 43214

This notice is effective as of the date below. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have read and received a copy of this notice.

_____	_____	_____
Name (Print please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Represented (Print please)	Signature	Date

Description of the authority to act on behalf of the patient: