BETTINA SCHULER
M.S., L.AC.

NOTICE OF PRIVACY FOR HIPAA REGULATIONS

This note describes general office practices regarding confidentiality of your medical records

Patient Health Information Rights

A record is made at each visit containing information regarding your symptoms, the practitioner's judgments, and a plan of treatment. This record is the physical property of the practitioner, but the content belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures.

Office Practices

- All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential. Patient chart and financial data will only be seen by the practitioner.
- Discussion of treatment is confined to the consultation room or treatment room, not in the presence of other patients.
- Your written consent is needed to disclose your health record to other health practitioners.
- There is no electronic transfer of your medical data from this office.

Communication

Communication for the purpose of scheduling or confirming appointments will routinely be done over the phone or by email. While the name of the practitioner, Bettina Schuler, will be given, no reference to medical services is made. Occasionally, a call is made to give instructions or to notify you that herbs and supplements are in the office.

Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Information may also be sent to you about treatment alternatives and other health-related benefits that you might find useful.

In these events, you have the right to request communication by alternate means or to alternate locations.

By signing below, I acknowledge that I have been provided a copy of this NOTICE OF PRIVACY PRACTICES and have therefore been advised how medical information may be used and disclosed in this office and have been informed on how I may gain access to and control this medical information.

_____ _____

Patient Name Patient Signature

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Date