



## NOTICE OF OUR PRIVACY PRACTICES

### Concordia Wellness, LLC

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

#### A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information ( IIHI ). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you . We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

*Concordia Wellness, LLC – [www.concordiawellness.com](http://www.concordiawellness.com)  
3014 NE Killingsworth St., Portland, OR 97211 – 503-449-7631 – [contact@concordiawellness.com](mailto:contact@concordiawellness.com)*

The terms of this notice apply to all records containing your IHHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice on our website at all times, and you may request a copy of our most current Notice at any time.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT :**

Kim Magraw, LMT

3014 NE Killingsworth St., Portland, OR 97211

503-449-7631

contact@concordiawellness.com

If you believe your privacy rights have been violated, use the contact information above to make a complaint. If after discussing the issue with us, we are not able to resolve your complaint or concern, you have the right to make a formal complaint, without fear of retaliation:

Secretary for Health and Human Services

200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201

**C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IHHI) IN THE FOLLOWING WAYS**

The following categories describe the different ways in which we may use and disclose your IHHI.

1. Payment. Our practice may use and disclose your IHHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IHHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IHHI to bill you directly for services and items.

2. Health Care Operations. Our practice may use and disclose your IHHI to operate our business. For example, our practice may use your IHHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

3. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment, as well as by email.
4. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
5. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
6. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
7. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

#### D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

I. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices

- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **Health Oversight Activities.** Our practice may disclose your IIIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. **Law Enforcement.** We may release IIIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

7. Research. Our practice may use and disclose your IIIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIIHI for research purposes except when : (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIIHI is being used only for the research and (iii) the researcher will not remove any of your IIIHI from our practice; or (c) the IIIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIIHI for worker's compensation and similar programs.

## E. YOUR RIGHTS

1. **Limiting Uses or Disclosures.** You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. Our practice is not required to honor these requests.
2. **Confidential Communication.** Our practice will attempt to accommodate any reasonable request regarding communication of your IIIHI, either by alternative means or at alternative locations.
3. **Amending Your Health Information.** You have the right to request that we amend your IIIHI for seven years from the date that the record was created or as long as the information remains in our files. Our practice require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.
4. **Inspecting/Copying Your Health Information.** You have the right to inspect your files while in our 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.
5. **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 treatment; to obtain payment for services; for health care operations; 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. Our practice 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, we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

This notice effective as of August 15, 2020.

# Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand the *Concordia Wellness, LLC, Notice of Privacy Practices* containing a description of the uses and disclosure of my health information. I further understand that *Concordia Wellness, LLC*, may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of the *Concordia Wellness, LLC, Notice of Privacy Practices* by submitting a request in writing.

Printed Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**If completed by patient's personal representative, please print name and sign below.**

Printed Patient Personal Representative Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Patient Personal Representative Signature \_\_\_\_\_

Date \_\_\_\_\_