Dr. Bush and the Staff of the Center for Integrative Healing Want You to Know How We Will Protect Your Identifiable Health Information

It is very important that you feel safe about telling your doctor and our staff personal information that may be required for your treatment. On April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPPA") which require us to share with you how your identifiable health information may be used. HIPAA regulations cover physicians and all other health care providers, health insurance companies and claims processing and billing staff. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans, and others healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil and criminal penalties; and
- Try to balance need for individual privacy with requirements for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that as of April 14, 2003 our practice shares with all of our patients our Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights in regard to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice. It is not required of you to sign this acknowledgment. If you do not wish to sign, we are required to document our efforts to share this Notice with you, and to document your decision not to sign this acknowledgement. If you have any questions about our Privacy Practices, please feel free to contact our office manager.

Thank you,

I acknowledge that I have been presented with the Notice of Privacy Practices.

Signature: ____________________ Print Name: ____________________ Date ____________________

☐ Patient declined to receive and review Notice of Privacy Practices

☐ Patient declined to sign acknowledgement of Notice of Privacy Practices

Noted by: ____________________ Date: ____________________

(Staff Member)

Revised 2010

-Dwana Bush M.D.-