William Lyden, D.C.,
D.A.C.B.N., D.A.B.C.I.
D.C.B.C.N.
Diplomate in Nutrition- Board Certified 1989, 2009
Diplomate in Internal Disorders- Board Certified 1990

MICHIANA
WELLNESS & LONGEVITY CLINIC

605 W. Edison Rd., Suite G
Mishawaka, IN 46545-8823
PHONE: 574-258-4444 FAX: 574-258-4445
Email: MWLC@SBCglobal.net
Website: www.MichianaWellness.com

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPAA)

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. Other than the uses and disclosures we described below, we will not sell or provide any of your health information to any outside marketing organization.

We must abide by the terms of this notice while it is in effect, but we reserve the right to change the terms of our privacy notices. If we make a change, it will apply for all of your health information in our files, and we will notify you in writing if/when you come in for treatment.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU NAY BE USED AND DISCLOSED

AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

All correspondence should be addressed to:

Attn: HIPPA Compliance Officer,
Michiana Wellness & Longevity Clinic
605 West Edison Rd., Suite G
Mishawaka, IN 46545-8823

USES AND DISCLOSURES

Here are some examples of how we might use or disclose your health information:

1. **We 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. **We may have to disclose your examination and treatment records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.**
3. **We may need to use any information in your file for quality control purposes or any other administrative purposes to run our practice.**
4. **We may need to use your name, address, phone number and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you (i.e. test results). 164.520 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine and/or be mailed.**

You have the right to refuse to give us authorization to contact you regarding your case at this office. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives, etc.).

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YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

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

1. **We are providing health care services on the orders (referral) of another health care provider.**
2. **We provide health care services to you in an emergency and we are unable to obtain your consent after attempting to do so.**
3. **If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.**

REVOKING YOUR AUTHORIZATION

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

1. **If we have already released your health information before we receive your request to revoke your authorization. 164.508(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 health information if they decide to contest any of your claims.**

CONFIDENTIAL COMMUNICATION

We will attempt to accommodate any reasonable written request regarding how or where (i.e. mailing address or contact number) you would like to receive information about your health or the services that we provide.

AMENDING YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We 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.

INSPECTING / COPYING YOUR HEALTH INFORMATION

You have the right to inspect the health information contained in your files while in our office and/or have a copy made for you. The health information is available up to seven years from the date the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/or have them copied. There will be a charge of $.50 per page copied. Copies can be made of x-rays for a charge of $10.00 for each film. The original film is the property of this office because we are required by law to keep it in our records. Original films can only be released on referral to another physician.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

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

- **Required for your treatment, to obtain payment, to run our practice, and/or made to you.**
- **Necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.**
- **For national security, intelligence purposes, or law enforcement officers.**
- **That were made prior to the effective date of the HIPAA privacy law (April 14, 2003).**

We 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.

RE-DISCLOSURE

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

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, D.C. 20201.

This notice is effective as of _____. 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.

_____ _____
Patient Name Printed **Date**

_____ _____
Patient Signature **Authorized Staff Person**

_____ _____
Personal Representative Printed **Personal Representative Signature**

_____
Description of personal representative's authority to act for the patient