New Heights
Health & Wellness

HIPAA Notice of Privacy Practices

Effective Date: _____

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your medical record.
- Ask us to correct your medical record.
- Request confidential communication (e.g., phone, mail, email).
- Ask us to limit the information we share.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice at any time.
- Choose someone to act for you (e.g., medical power of attorney).
- File a complaint if you feel your privacy rights are violated.

Your Choices

You have the right to tell us how to share information in situations such as:

- Family, friends, or caregivers involved in your care.
- Disaster relief or emergencies.
- Inclusion in hospital directories.

We will never share your information unless you give us written permission for:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

Our Uses and Disclosures

We may use and share your information to:

- Treat you (with other healthcare providers).
- Bill for services (insurance, Medicare/Medicaid).
- Run our practice (quality assessment, accreditation, compliance).
- Public health and safety issues (disease reporting, product recalls).
- Research (if approved by an oversight board).
- Law enforcement, court orders, and legal proceedings.
- Respond to organ donation and medical examiner/coroner requests.
- Comply with workers' compensation, military, or government requests.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We will notify you promptly if a breach occurs that may compromise your information.
- We must follow the duties and privacy practices described in this notice.
- We will not use or share your information other than as described here unless you tell us we can in writing.

Contact Information

For questions, requests, or complaints regarding your privacy rights:

Privacy Officer: New Heights Health and Wellness

Phone: (_____) _____ -_____

Email: _____

Address: _____

You may also file a complaint with the **U.S. Department of Health & Human Services** at 1-877-696-6775 or www.hhs.gov/ocr/privacy.

HIPAA Acknowledgment of Receipt of Privacy Practices

I, _____ (patient name), acknowledge that I have received a copy of the **Notice of Privacy Practices** from **New Heights Health and Wellness**.

- I understand this notice explains how my health information may be used and shared.
- I understand that I may request additional restrictions or revoke this acknowledgment at any time.

Patient/Representative Name (print): _____

Signature: _____

Date: _____

If signed by a patient representative:

Relationship to Patient: _____