PRIVACY POLICIES

This notice describes how medical information about you may be used and disclosed and your access to it. Protected health information about you is obtained as a record of your visits or contacts with Dr. Melissa Reed, MD and Staff for healthcare services. Specifically, PROTECTED HEALTH INFORMATION is information about you, including demographic information (name, address, age, etc.) that may identify you and may relate to your past, present and/or future physical or mental health condition(s) and related healthcare services.

Dr. Reed is required to follow specific rules for maintaining the confidentiality of your protected health information, the use of your information and how she discloses or shares this information to/with other healthcare professionals involved in your care and treatment. This Policy describes your rights to access and control your protected health information. It also describes how we follow those rules in the use and disclosure of your protected health information for the purposes of providing treatment, obtaining payment for the services you receive, managing our healthcare operations and for other purposes permitted/required by law.

YOUR RIGHTS UNDER THE PRIVACY RULE

The following is a statement of your rights under the Privacy Rule in reference to your protected health information. Please feel free to discuss any questions/concerns with the staff.

YOUR RIGHTS TO A COPY OF PRIVACY POLICIES

We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain. Upon request, you will be provided with a revised Notice of Privacy Policies.

YOUR RIGHTS TO AUTHORIZE OTHER USE AND DISCLOSURE

This means that you have the right to authorize or deny authorization for any other use/disclosure of protected health information not specified in this notice. You may revoke an authorization at any time except to the extent that Dr. Reed or her staff has taken an action in reliance on the use or disclosure indicated in the authorization. Any revocation of authorization to use or disclose protected health information must be presented in writing.

YOUR RIGHTS TO DESIGNATE A PERSONAL REPRESENTATIVE

This means that you may designate a person who then has the delegated authority to consent to or authorize the use or disclosure of your protected health information. Any notice of revocation of authorization/designation of a previously named personal representative must be presented in writing.

YOUR RIGHTS TO YOUR PROTECTED HEALTH INFORMATION

This means that you may inspect and obtain a copy of protected health information about you that is contained in your patient record. Under certain circumstances, we may deny your request. Any requests for copies of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

This means that you may request, in writing, that we not disclose any part of your protected health information for the purposes of treatment, payment for service you have received, or healthcare operations. You may also request that any part of your protected health information be restricted from disclosure to others who may be involved in your care or for notification purposes as described in this Notice of Privacy Policies. Under certain circumstances, we may deny your request for restriction. All requests for restriction of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST YOUR PROTECTED HEALTH INFORMATION AMENDED

This means that you may request an amendment of your protected health information for as long as we maintain the information. Under certain circumstances, we may deny your request for an amendment. All requests for amendment to your protected health information must be made in writing.

PRIVACY POLICY AUTHORIZATION

PLEASE INITIAL ALL STATEMENTS

You have certain rights regarding your protected health information under the Health Insurance Portability and Accountability Act (HIPPA). This document allows you to specify under what conditions your protected health information may be used or disclosed. HIPAA gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). Please initial what type(s) of information and for what purpose(s) you authorize us to disclose your protected health information.

_____ I understand that Dr. Melissa Reed, MD and Klarity Wellness Clinic reserve the right to change notices and practices and that I will be given new notification, upon request, if this occurs. I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or healthcare operations.

_____ Dr. Melissa Reed, MD and staff may release any/all medical information needed to determine payment for services. I understand that without this particular authorization no claims can be filed with my insurance company and I will be responsible for paying in full for all medical services provided at the time of service.

_____ I understand that I may revoke this consent in writing, except to the extent that Dr. Melissa Reed, MD, Klarity Ketamine Wellness Clinic, and support staff have already taken action in reliance thereon. I also understand that Dr. Melissa Reed, MD and her support staff are not required to adhere to the restrictions requested in the event of a potentially life-threatening emergency.

_____ Dr. Melissa Reed, MD and staff may release protected health information to HIPAA covered entities on my behalf. This includes, but is not limited to, health/insurance plans, other healthcare providers, healthcare claims clearinghouses and others.

_____ I understand that I am also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to your office instead of to your home. Dr. Melissa Reed, MD and staff may contact me in the ways specified below for appointment reminders and/or general information (check one or all that apply):

Home Phone	Cell Phone	Work Phone	Personal Email	Home Voicemail	Cell Voicemail	Work Voicemail

_____ Dr. Melissa Reed, MD and staff may communicate verbally and/or via email with others (including but not limited to family members who may answer the phone/check email) regarding appointments, test results and other general information. Please initial the types of information you authorize Dr. Reed and/or her staff to disclose (choose one or all that apply):

	ALL information in the medical chart can be disclosed
	ONLY the information detailed here:

List all approved persons who can receive information on your behalf:

1._____ 2. _____ 3._____

_____ I understand this release may include records that contain information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to Medicare, Medicaid or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or the patient's employer. (The patient's employer will only be contacted if necessary to confirm enrollment in a healthcare plan).

MY SIGNATURE BELOW SIGNIFIES THAT I HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THE NOTICE OF PRIVACY POLICIES. IN ADDITION I UNDERSTAND THAT THE ABOVE AUTHORIZATIONS MAY BE REVOKED AT ANY TIME BY WRITTEN NOTICE TO DR. MELISSA REED, MD. ANY REVOCATION WILL BECOME EFFECTIVE ON THE DATE IT IS RECEIVED BY THE OFFICE OF DR. MELISSA REED, MD. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT LIMIT THE TREATMENTS AVAILABLE TO ME; IT ONLY AFFECTS THE USE OF MY PROTECTED HEALTH INFORMATION. I ACKNOWLEDGE AND UNDERSTAND THAT USES AND/OR DISCLOSURES OF MY PROTECTED HEALTH INFORMATION BY HIPAA COVERED ENTITIES RECEIVING INFORMATION MAY OCCUR AND UNDER THESE CIRCUMSTANCES, I ABSOLVE DR. MELISSA REED, MD AND MEMBERS OF HER STAFF OF ANY RESPONSIBILITY AND/OR LIABILITY FOR SUCH USE AND/OR DISCLOSURE.

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SIGNATURE OF PATIENT/GUARDIAN PRINTED NAME DATE