HIPAA Notice
Client Notice/Affidavit of Privacy Practices

Vitality Integrative Medicine Clinic
Christopher Lawinski, MD
Dr Sally Boyd, ND
15-3039 Pahoa Village Road, Pahoa, HI 96781

Client's Name_________________________ **Client DOB:_______________________**

Purpose:

This notice describes your rights, as well as how we might disclose your public health information (PHI) to the minimum degree that is necessary for treatment, payment, healthcare regulations and/or other purposes permitted or sanctions by public law. Public health information is any information generated or collected by us, such as demographic information or information relating to your past, present, or future mental health or condition. The types of information contained in your PHI include clinical billing invoices, payment forms or other documentations that are maintained in paper, electric or some other form.

We respect your privacy and are committed to protecting the confidentiality of your health-care information without interfering with your access to healthcare. We are required by federal law to maintain the privacy of your protected confidential information or "PHI", and to give you advance notice of our legal duties and privacy practices. We reserve the right to conduct privacy practices regarding your public health information and provide you with a notice of any changes described in this notice. We will not disclose public health information without your written consent.

Procedures for the following rights to release private health information:

As required by law, Dr. Chrisopher Lawinski and Dr. Sally Boyd provide clinical health services, must disclose PHI about you when required to do so by law.

1. For treatment purposes: During the course of your treatment, the physician might share your PHI with a specialist to coordinate the best care for you.
2. For Payment purposes: We may submit requests for payment to your insurance company.

Dr. Christopher Lawinski and Dr. Sally Boyd may use and/or disclose information for the purposes of purposes of our day-to-day operations and functions. We may also disclose your information to another health - care provider to allow them to perform their day-to-day functions, but only to the extent that we both have a relationship with you. For example, we may compile your health information along with that of other consumers in order to allow our healthcare professionals to review that information and make suggestions concerning how to improve the quality of care provided by us. We refer to that process as our Agency/Provider Quality Assurance Peer Review meetings. All efforts to minimize any identifying information are made when peer-reviewed processes are performed.

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Public health purposes: As authorized by law, we may disclose your PHI to public Health or legal authorities charged with preventing or controlling disease, injury, or disability: to report reactions to medications or problems with products: to notify people of recalls: to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Health oversight activities: We may disclose public health information about you to an oversight agency to conduct audits and civil, administrative or criminal investigations as authorized by law. Some of these oversight activities are necessary for license, accreditation and compliance with contracts.

Judicial/Administrative Proceedings: We may disclose you PHI in the course of any judicial or administrative proceeding as allowed or required by law, with you authorization, or as directed by a proper court order.

Organ, eye or tissue donation: We may disclose your public health information to organ or tissue procurement entities as applicable by law.

Research purposes and projects: We may disclose public health information about you to researchers when a research approval process that takes into account consumer rights to privacy has evaluated the research.

a. To avert a serious threat to health and safety: We may disclose public health information about you to avert a serious threat to your health and safety or the health and safety of the public or another person.
b. Governmental functions: We may disclose public health information about you for specialized governmental functions such as military, national security, criminal corrections or public benefit purposes.
c. Workers Compensation: we may disclose public health information about you to comply with laws related to Workers Compensation and/or other programs established by law.

Other Uses: Other situations where indirect disclosure may occur, such as during scheduling, voice messages, billing, invoicing, co-payments

Except in emergency situations, we will inform you of the intended disclosure and will offer you the opportunity to object. In all other situations, we will obtain your written permission before using or disclosing public health information about you for purposes other than those stated above. You may revoke your written permission at any time. Upon receipt of your approval of your revocation request, we will stop using or disclosing public health information about you, except to the extent that it is already been done so prior to your revocation.

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What if your privacy rights are violated: If you feel your privacy rights have been violated we want to hear from you. You may file a company with our privacy Officer listed below or you may file a complaint with the Secretary of the Federal Department of Health and Human services. There will be no retaliation against you for filing a complaint.

Please contact privacy officer: Don Doughtrey, P.O. Box 1233, Pahoa, HI 96778.

We will maintain a signed paper copy of this notice and will provide you upon request. You may request a copy of this notice at any time by calling our office at 808-965-2233.

RIGHTS/RESPONSIBILITIES ACKNOWLEDGEMENT

I have reviewed the "Bill of Rights", listed below and a verbal explanation of medical rights has been explained to me and questions have been satisfactorily answered. I understand that, if needed, my rights under advisor/designated HIPPA agent: David A. Kazmierczak, LCSW; will assist me in filing a complaint and facilitate an investigation on my behalf.

Bill of Rights:

1. Right to refuse treatment
2. Right to different or second option of treatment.
3. Right to confidential treatment.
4. The right to complain about treatment without fear of retaliation.
5. To understand my diagnosis/prognosis and be a part of the treatment planning process.
6. The right to least restrictive treatment.
7. The right not to be involved in experimental treatment without my consent.
8. The right not to be involved in experimental treatment without my consent.

DUTY TO REPORT: DANGER TO SELF/OTHER & CHILD PROTECTIVE SERVICES

We are required to report danger to self or other. All Human service providers, teachers, and day care providers in the State of Hawaii are required by state law to report any suspected abuse or neglect of a child to Child Protective Services so that the family can receive help. Failure to report can result in fines and/or imprisonment.

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If unexplained bruises or injuries are noted on your child, we want you to know that we will discuss the situation with you. If a report to CPS must be made, we will inform you of this. Please remember that our goal and the goal of CPS are not to punish parents, but to help families that are in trouble.

Use of Interns and Resident policy:

I understand that this practice may use University students, and/or non-licensed residents in training under the supervision of an ND/MD. I understand that I have the right to accept or refuse a resident in training as part of my treatment.

______________________________	____________	______________________________	____________
Signature: Client	**Date**	**Print: Client**	**Date**

PERMISSION FOR USE OF INSECURE ELECTRONIC TECHNOLOGY

PERMISSION FOR USE OF NON SECURE ELECTRONIC TECHNOLOGY IN TREATMENT AND OR COMMUNICATION
I, understand by signing this release, I give full consent to participate in text messaging (for scheduling purposes) with full understanding that it does not meet HIPAA security requirements.

I AM FULLY INFORMED THAT THIS TECHNOLOGY USES THE WORLD WIDE WEB (INTERNET) CELLULAR TECHNOLOGY AND DOES NOT MEET THE FULL STANDARDS FOR CONFIDENTIALITY AND SECURE COMMUNICATIONS REQUIRED OF THE HEALTH INFORMATION PORTABILITY AND PROTECTION ACT (HIPPA COMPLIANCE).

This document has been read carefully and/or been explained to me, and I understand privacy practices and how health care information may be used or disclosed. I'm aware that the notice or privacy practices may be changed at any time and I may obtain a revised copy of these changes by contacting the privacy officer at 808-965-2233.

I also understand and agree that this protected information is maintained, kept and locked in a locked closet that is shared by both doctors. Where access is restricted to staff and owners of Vitality Integrative Medicine Clinic, LLC.

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Client/Parent/Guardian name (print) ____

Client/Parent/Guardian name [sign] ____

Date:________________________

I am satisfied that the above person understands his/her public health information rights and complaint process.

Staff________________________________ (Print) Staff________________________________ (Sign)

Date________________________

Consent for Inter Physician Information: OBTAIN & RELEASE Form

(All Clien**t information for both agencies is kept in one HIPPA room**)

I hereby authorize & request Clinical providers: Physicians, Dr. Lawinski, MD and Dr. Boyd Daughtrey ND to release privileged information to each other. This agreement includes Title 42 Alcohol/Drug, HIV related information, unless expressly prohibited to do so in writing to all aforementioned parties. This is for ___________________(client), for whom I have legal authority to act. This is for communication between physicians and the *purpose of this disclosure is to coordinate and facilitate evaluations, treatment and treatment planning for the above named client, I understand that my records are protected under federal and state regulations mandating confidentiality and may not be disclosed without my written consent (unless there is danger to self or others requiring duty to report). I also understand that I may revoke this consent at any time except to the extent of actions already initiated relying upon this consent. Unless I revoke, this consent expires in one year from the date of signature below*.

(*Check the appropriate spaces*)	**OBTAIN**	**RELEASE**
Dr. Sally Boyd-Daughtrey	______	______
Dr. Christopher Lawinski	______	______

______________________________ Date:_____________

Signåture Client/Parent/Guardian

Next Annual Renewal Date: _______________

______________________________ Date:________________

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Signature Client/Parent/Guardian

Next Annual Renewal Date:_________________

Federal and State Law prohibit further disclosure without additional consent and limit the terms of this **agreement by the identified renewal dates.**