**HEALTHY LYMPHATICS OF NC, PC**

**Phone: 828-355-9584**

**Fax: 828-355-9689**

**Healthy Lymphatics-Boone office Healthy Lymphatics-Elkin office Healthy Lymphatics-Mt. Airy office**

**450 New Market Blvd Ste 3 2015 North Bridge St 905 Rockford St**

**Boone, NC 28607 Elkin, NC 28621 Mount Airy, NC 27030**

 **Healthy Lymphatics-North Wilkesboro office Healthy Lymphatics-Galax VA office**

 **1912 West Park Drive 812 West Stuart Drive**

 **North Wilkesboro, NC 28659 Galax, VA 24333**

 **NOTICE OF PRIVACY PRACTICES**

 **Protected health information about you is maintained as a record of your contacts or visits for physical**

 **therapy services with our practice(s). Specifically, “protected health information” is information about**

 **you, including demographic information (i.e., name, address, phone, etc.) that may identify you and**

 **relates to your past, present or future physical health condition and related health care services.**

 **Our practice is required by law to follow specific rules on maintaining the confidentially of your**

 **protected health information, using your information and disclosing or sharing this information with**

 **other healthcare professionals involved in your care and treatment. This notice describes your rights**

 **to access and control your protected health information. It also describes how we follow applicable**

 **rules and use and disclose your protected health information to provide your treatment, obtain payment**

 **for services you receive, manage our health care operations and for the other purposes that are**

 **permitted or required by law.**

 **We are required to abide by the terms in the notice. We reserve the right to change the terms of this**

 **notice at any time and those changes will go into effect at that time. Upon request we will provide you**

 **with a copy of the revised notice.**

 **YOUR RIGHTS UNDER THE PRIVACY RULE**

 **You have the right to receive a copy of this notice. You have the right to authorize other use and**

 **disclosure. You may authorize or deny any use or disclosure and you may revoke your authorization**

 **at any time, in writing.**

 **You have the right to designate a personal representative who will have the authority to authorize the**

 **use or disclose your protected health information. You have the right to inspect and copy your protected**

 **health information. We have the right to charge a reasonable fee for copies as established**

 **professional, state or federal guidelines.**

 **You have the right to request a restriction of your protected health information by asking us in writing**

 **not to use or disclose any part of your protected health information for the purposes of treatment,**

 **payment or healthcare operations. In certain cases, we may deny your request for a restriction. You also**

 **have the right to request disclosure accountability by requesting a listing of disclosures that we have**

 **made to entities or persons outside of our office.**

 **HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

 **We may use and disclose your information to provide, coordinate or manage your physical therapy**

 **treatment. Specifically, this would involve your referring physician, workers compensation case**

 **manager and/or adjuster. We will also disclose your information to obtain coverage and benefits**

 **as well as payment from your insurance carrier.**

 **COMPLAINTS**

 **You may complain to us or the Centers of Health and Human Services if you believe your privacy rights**

 **have been violated by us. You may file a complaint with us by notifying us in writing. Our mailing**

 **address is HEALTHY LYMPHATICS OF NC, PC-450 NEW MARKET BLVD., SUITE 3, BOONE, NC 28607.**

 **PATIENT HEALTH INFORMATION RELEASE**

 **I have read and fully understand HEALTHY LYMPHATICS OF NC, PC’s Notice of Information Practices. I**

 **understand that HEALTHY LYMPHATICS OF NC, PC may use or disclose my personal health information**

 **for the purposes of carrying out treatment, obtaining payment from insurance companies, evaluating**

 **the quality of services provided and any other administrative operations related to treatment or**

 **payment. I understand that I have the right to restrict how my personal health information is used and**

 **disclosed for treatment, payment and administrative operations if I notify the facility in writing. I also**

 **understand that HEALTHY LYMPHATICS OF NC, PC will consider requests or restrictions on a case-by-case**

 **basis, but does not have to agree to requests for restrictions.**

 **I hereby consent to the use and disclosure of my personal health information for purposes as noted in**

 **HEALTHY LYMPHATICS OF NC, PC’s Notice of Information Practices. I understand that I retain the right**

 **to revoke this consent by notifying the company in writing at any time.**

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 **PATIENT PRINT NAME**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **PATIENT SIGNATURE**

 **\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **DATE**