White Lotus Acupuncture and Massage
Desiree Sterling, L.Ac., MS

This notice describes how health information about our patients may be used and disclosed, and how you can get access to your health information.

This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy
Our Practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and Disclosure of Your Health Information to Certain Special Circumstances
The following circumstances may require us to use or disclose your health information:

1. To public health authorities/health oversight agencies authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
6. To Federal Officials for Intelligence and national security activities authorized by law.
7. For Worker's Compensation and similar programs.
8. Data collected by Desiree Sterling, L.Ac., which does not include the identity of the patient, may be utilized for research purposes.

Your Rights regarding Your Health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information which may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Desiree Sterling, L.Ac., 4054 Centre Street, San Diego, CA 92103 at (619)535-8441, who will have 30 days to comply to your request
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Desiree Sterling, L.Ac., 4054 Centre Street, San Diego, CA 92103 at (619)535-8441 who will have 60 days to respond to your request. You must provide us with a legitimate reason that supports your request for amendment.

5. You are entitled to receive a copy of this Notice of Privacy Practices at any time.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint contact Desiree Sterling, L.Ac., 4054 Centre Street, San Diego, CA 92103 at (619)535-8441. All complaints must be submitted in writing; you will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your health care provider. I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practice

Signature_____Date_____

Print Name_____

General Authorization to release Health Information

I hereby authorize the release of my personal health information to any health provider approved by my treating health care provider. I understand that I may cancel this authorization at any time by notifying my treating health care provider at any time.

Signature_____Date_____

Print Name_____