# Notice Of Privacy Practices

**Your Information. Your Rights. Our Responsibilities.**

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

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**Your Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct certain mistakes on your medical record
- Request confidential communication
- Ask us to limit the information we share under certain circumstances
- Get a list of certain disclosures of your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**Your Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

**Our Uses and Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters).

**Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share.**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/ hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

**Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

**Tell us what you want us to do, and we will follow your instructions.**

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

**Our Uses and Disclosures**
How do we typically use or share your health information? We typically use or share your health information in the following ways.

**Treat you**
We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**
We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/ understanding/consumers/index.html.

**Help with public health and safety issues**
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**
We can use or share your information for health research.

**Comply with the law**
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**
We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**For more information see:**
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/ noticepp.html.

**Changes to the Terms of this Notice**
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

**Organizations**
This Notice of Privacy applies to all affiliated entities doing business as The ExerScience Center.

**Contact**

The ExerScience Center
24706 State Road 54
Lutz. Fl 33559
Phone: 813.803.7070
Email: info@theexersciencecenter.com

**Effective Date of this Notice:** July 1, 2020

The ExerScience Center

# HIPAA Privacy Practices Acknowledgment

## Section A: Patient Information

Patient Name: _____

Patient Number: _____

## Section B: Acknowledgment Of Receipt Of Hipaa Notice Of Privacy Practices

**Notice of Privacy Practices:** Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Acknowledgment. We encourage you to read our Notice carefully and completely before signing this Acknowledgment.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain an additional copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

The ExerScience Center
**Telephone:** 813.803.7070
**Email:** info@theexersciencecenter.com

## Section C: Signature

I, _____ have had full opportunity to read and consider the contents of this Acknowledgment and the Notice of Privacy Practices. I understand that, by signing this Acknowledgment, I am giving my authorization to your use and disclosure of my protected health information in accordance with the Notice.

Signature: _____ Date: _____

*If this Acknowledgment is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:*

Personal Representative's Name: _____ Relationship to Patient: _____

## Section D: For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other *(please specify):* _____

Signature: _____ Date: _____

*You are entitled to a copy of this acknowledgment after you sign it.*

# The ExerScience Center

# HIPAA Authorization

**HIPAA Authorization for Uses and Disclosures of Protected Health Information**

**Authorization of Uses and Disclosures.**
I hereby authorize and direct The ExerScience Center as well as their associated dentists, providers, employees, office staff, and agents including affiliated health care practitioners (collectively "The ExerScience Center") to use and disclose my "protected health information" ("Information"), as described below.

**Description of Information.**
I understand that my Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical information, including information about my health condition and related medical conditions, medical records, and financial information (including information about my insurance) as well as other personal information collected by The ExerScience Center about me or otherwise provided by me to The ExerScience Center.

**Purposes.**
I authorize and direct The ExerScience Center to use my Information, and to disclose my Information for the following purposes:

a. **For marketing communications.** For example – The ExerScience Center may contact me about new products, services, or events that it thinks may be of interest to me. The ExerScience Center may also contact me for the purposes of fundraising, publicity and advertising for broadcast in print or other media including on the internet. Note that The ExerScience Center may receive remuneration, either directly or indirectly, in exchange for making these marketing communications.

b. **For purposes related to treatment, payment (e.g., to a parent, other family member or personal representative who may assist in coordination of my care) and/or The ExerScience Center health care operations, with the following individuals:**

**Name:** _____

**Relationship:** _____

**Telephone Number:** _____

**Treatment not Conditioned; Signing is Voluntary.**
I understand that The ExerScience Center will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization and will still be able to receive treatment. In addition, if I refuse to sign this Authorization The ExerScience Center is still permitted to make uses and disclosures of my Information for treatment (e.g., to other health care providers), payment (e.g., to my insurance company), and health care operations (e.g., for internal audits), as permitted by law.

**Expiration.**
Unless revoked, this Authorization will expire ten (10) years from the date signed below.

**Revocation.**
I understand that I have the right to revoke this Authorization by providing written notice of my desire to revoke to **The ExerScience Center**, however, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.

**Potential for Redisclosure.**
I understand that Information disclosed pursuant to this Authorization may be redisclosed by The ExerScience Center and may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"), a federal privacy law.

**Copy.**
I understand that I will be provided with a copy of this signed Authorization.

**I hereby certify that I am over the age of 18 and I have read the foregoing and fully understand the contents.**

Name *(please print)*: _____

Patient Signature: _____ Date: _____

Date of Birth: _____ Age: _____

***Parent/Guardian/Personal Representative Signature (required if subject is under 18 years of age)***

Description of Relationship to Patient: _____