

Mountain State Wellness, PLLC Privacy Statement

This notice describes how your health information may be used and disclosed and how you can obtain this information. Please review it carefully.

During the course of your care as a member at Mountain State Wellness, PLLC we may use or disclose personal health information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for your reimbursement of services rendered to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information regarding your care, or other health related information that may be of interest to you (i.e. newsletter).

You have the right to request restrictions on our use of your protected health information for treatment, payment, and operations. Such requests are not automatic and require the agreement of this office.

You may receive an appointment reminder or other related information as a message on your answering machine or with a person in your residence. You have the right to confidential communications and to request restrictions related to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have the right to receive documentation of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be granted with your written authorization. If you provide a written authorization for release of your health information, you have the right to revoke that authorization in the future.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Our standard procedures are to inform you about your health care during your scheduled appointments. We may also mail information to you regarding your health care or your account balance. If you would like to receive this information at an address other than your residence, a written request is required.

You have the right to inspect, amend and/or copy your health information for as long as the information remains in our files. Requests to inspect, amend and/or copy your health information are required to be in written form.

We are required by state and federal law to maintain the privacy of your member file and the protected health information therein. We are also required to provide you with a copy of this privacy statement. We are also required by law to abide by the terms of this privacy statement.

We reserve the right to alter or amend the terms of this privacy statement. If this privacy statement is amended, we will notify you in writing as soon as possible. Any amendments will apply to all of your protected health information in our files.

If you have a complaint/inquiry regarding our privacy statement or our privacy practices, you should inquire with Drs. Lucas and/or Amy Watterson.

You also have the right to file a complaint with the Secretary of the Department of Health and Human Service. If you choose to file a complaint with this office or the Secretary of HHS, you are entitled to continue care without any discrimination from this office.

This statement and any amendments made hereto will expire seven years after the date upon which the record was signed. My signature below acknowledges that I have received a copy of this privacy statement.

Printed Name	Signature	Date
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***If you are a minor, or if you are being represented by another person**

Representative Printed Name	Representative Signature	Date
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Description of the authority to act on behalf of the member.