NOTICE OF PRIVACY PRACTICES

Golden Needle Acupuncture Clinic
2274 NW Raleigh St, Portland, OR 97214 /503.323.0452

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, your rights concerning your health information, and our legal duties. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 07-15-2008, and will remain in effect until we replace it.

We reserve the right to change our privacy practices in the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

PATIENT RIGHTS
Access: You have the right to get copies of your health information. You must make a request in writing to obtain access to your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

NOTICE OF PRIVACY PRACTICES

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as this office keeps the information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create
- Is not part of the health information that we maintain
- You would not be permitted to inspect and copy
- Is accurate and complete

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Electronic Notice: If you receive this notice on our web site or by e-mail, you are entitled to receive this notice in written form.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. To file a complaint please contact us at the number or address listed on the top front page of this notice. You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____ (patient full name), hereby acknowledge that Golden Needle Acupuncture Clinic has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Golden Needle Acupuncture Clinic
2274 NW Raleigh St, Portland, OR 97210
(p) 503-323-0453 (f) 503-323-0452

I also understand that I am entitled to receive updates upon request if Golden Needle Acupuncture Clinic amends or changes its Notice of Privacy Practice in a material way.

_____
Signature and Relationship to Patient (if signed by someone other than patient)

_____
Date

THIS SECTION IS TO BE COMPLETED BY CLINIC/PROVIDER IF UNALE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:
[ ] Patient declined to sign this Written Acknowledgement
[ ] Other (specify):

_____ _____
Name and title of employee Date