PLEASE KEEP THIS PAGE

ALTERNATIVE HEALTH SOLUTIONS, LLC

NOTICE OF PRIVACY PRACTICES
ABRIDGED EDITION

Effective April 14, 2003, the Department of Health & Human Services implemented federal privacy laws (HIPAA) to provide protection for patient health care information. HIPAA guidelines state who we may disclose information to without your authorization and how we can disclose your protected health information with your authorization.
They also provide for your right to gain access to your personal health information, or make a complaint to the Department of Health & Human Services, if you feel your protected health information has been used In an improper way. This notice provides brief description of our unabridged Notice of Privacy Practices, which is also available.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
So that this office can treat you, receive payment for that treatment and conduct normal activities associated with running a health care practice, we may use your protected health information without your authorization to cooperate with third party payers, administrators, etc.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION
With your signed authorization, we may communicate with you to promote products and services that may not be for a specific purpose of providing treatment advice. You have the right to revoke this authorization.

PERMITTED AND REQUIRED USES/DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT
We may disclose to a member of your family, a relative, a close friend or other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also disclose your protected health information to an authorized public or private entity as required by law, for health oversight, legal proceedings and/or research.

RIGHT TO RECEIVE COPY OF PROTECTED HEALTH INFORMATI ON
You may inspect or obtain a copy of your protected health information for as long as we maintain that information unless protected by federal law.

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION
You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, receiving payment for that treatment or in conducting normal activities associated with running a health care practice. Also, you may request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care. Your request must be in writing and state specific restrictions requested, and to whom it applies.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION FROM US AT ALTERNATIVE LOCATION OR BY ALTERNATIVE MEANS
You may request to receive communication from us at an alternative location or by other means than those normally used to communicate with patients.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION
You may request an amendment to your protected health information for as long as we maintain that information. In certain cases we may deny your request for an amendment.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES WE HAVE MADE
You have the right to receive an accounting if we receive a request for disclosure of information for purposes other than treatment, payment for that treatment or in conducting normal activities associated with running a health care practice.

RIGHT TO OBTAIN A COMPLETE COPY OF THE NOTICE OF PRIVACY PRACTICES
You have the right to receive a complete copy of our unabridged Notice of Privacy Practices on paper or electronically.

COMPLAINTS
If you believe your privacy rights have been violated, you may state your complaint to us or to the U.S. Secretary of Health & Human Services.

ALTERNATIVE HEALTH
Solutions

RECORD OF PRIVACY PRACTICES DISCLOSURE

I acknowledge that Alternative Health Solutions, LLC "Notice of Privacy Practices" has been provided to me. I understand that I have a right to review the Alternative Health Solutions, LLC Notice of Privacy Practices prior to signing this document.

The Notice of Privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of Alternative Health Solutions, LLC. This notice also describes my rights and Alternative Health Solutions duties with respect to my health information.

Alternative Health Solutions, LLC reserves the right to change the practices that are described in the Notice of Privacy Practices. I understand that I may obtain a current copy of the notice by requesting a copy to be sent by mail, or by requesting same at the administration desk at the time of my appointment.

I understand that I have the right to revoke this consent in writing, except to the extent that Alternative Health Solutions has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding of and agreement to its terms.

I understand that I am responsible to inform Alternative Health Solutions, LLC of future changes in my personal contact information, as such changes may occur. I further understand that Alternative Health Solutions, LLC cannot be held responsible for using information that may, in time, become outdated, or for attempts to contact me by telephone and/or correspondence by mail, to outdated phone numbers and/or addresses respectively.

_____	_____
Name of Patient	Patient Signature (or signature of personal representative)
_____	_____
Date	Personal representative's relationship to Patient

PLEASE RETAIN THE FIRST PAGE OF THIS DOCUMENT FOR YOUR RECORDS.

SIGN AND RETURN THIS PAGE ALONG WITH YOUR COMPLETED FORMS.