MIDDLE WAY ACUPUNCTURE INSTITUTE

Acknowledgement of Health Information Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about Middle Way Acupuncture Institute's "Notice of Health Information Practices." For more details, please read the "Notice of Health Information Practices" that the Student Clinic has provided for you.

I. How we may use and share health data about you:

a) Treatment – To give you acupuncture treatment
b) Educations –To use your medical information as an educational tool for improving care.
c) To use among students and faculty who contribute to your care.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by federal, state, or local law
c) If child/elder abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Persons involved in your care or payment for your care. We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the law that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to receive communication from us about your health information in alternate ways
e) Right to a paper copy of the complete Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this office's Notice of Health Information Practices. I understand that if I have questions or complaints regarding my privacy rights, I may contact Roland Matthews, Director, at 360-336-6129 and/or the Department of Health and Social Services. I further understand that this office will provide me with updates to the Notice of Health Information Practices should it be amended, modified or changed in any way.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Print Patient Name Patient Date of Birth