9 East High St. (Rear) . Carlisle, PA 17013 . (717) 440-0498 . FAX (717) 918-5784

Name_____DOB_____

PRIVACY NOTICES

NOTICE OF PRIVACY PRACTICES: This notice provides information on how BrightStar Health and Wellness in MA and Peaceful Balance Health and Wellness in PA ("The Practice") will use and disclose your Protected Health Information (PHI). This notice also explains important rights you have regarding your PHI. "The Practice" reserves the right to change this Privacy Notice at any time.

USE AND DISCLOSURE OF INFORMATION: We will use and disclose your PHI for a variety of treatment, payment, and healthcare operations purposes. Such disclosure of your PHI may be made via mail, telephone, facsimile (fax), modem, email, and/or internet as may be necessary for "The Practice" to conduct business for these purposes. If your PHI contains any privileged or additionally protected information under State of Federal Law (such as HIV testing/status, mental health records, or sexually transmitted infection (STI) etc.) you will be asked to sign a specific authorization for the release of this additionally protected information. All PHI at "The Practices" will be handled in accordance with the Health Information Portability and Accountability Act of 1996.

Specifics of the HIPAA of 1996 can be found on the CDC website at https://www.cdc.gov/phlp/publications/topic/hipaa.html#:~:text=The%20Health%20Insurance%20Portability%20and,the%20patient's%20consent%20or%20knowledge.

RELEASE OF INFORMATION TO SPECIFIED PARTIES: I understand that I have can consent to the release of my PHI to specified parties. I have indicated below my preference in the release of my PHI to specified parties.

☐ I DO NOT give permission to "The Practice" to release my medical information to anyone – with the exception of the release of my PHI in order to facilitate emergency or urgent medical care and restrict the release of that information to that which is necessary for the treatment of said emergency.

☐ I give permission to "The Practice" to speak with and release to my PHI to the following individuals:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

RESTRICTIONS ON USE AND DISCLOSURES: You have the right to request how "The Practice" uses and discloses your health information for the purposes of treatment, payment, and healthcare operations and disclosures to family and friends. You also have the right to ask us to send communications including your PHI to an address, phone number (text), or e-mail of your choice. You also have the right to advise us on how to leave communications (ie. messages on a voicemail or answering machine, with a person who answers the phone). These instruction should be outlined on the communications document included in this packet.

Signature_____ Date_____

Practice Representative_____

I understand that I can revoke this consent in writing, except to the extent that "The Practice" has already taken action in reliance on it. I understand that if I revoke this consent "The Practice" may refuse to provide me with treatment. I also understand that this consent authorizes "The Practice" to use and disclose all past information documented in my medical record in accordance with the Privacy Notices provided. _____Initials