VITAE
INTEGRATIVE MEDICAL CENTER

Privacy Notice & Acknowledgement of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date. If you would like a copy of our Privacy Practices, they are available at the reception desk.

_____ ***(initial)*** I acknowledge and agree that I have been offered a copy of Vitae Integrative Medical Centers Privacy Practices. I understand that this is available to me at any time upon request.

Protected Health Information (PHI) may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

Our office follows HIPAA regulations in regards to protecting your health care information. As such, our office must have each patient's written consent to release PHI to any outside agency. Our office uses an outside billing agency to file our insurance claims. If you would like us to file for medical services provided, we must release your demographic information, insurance information and medical information. Our billing agency is also bound by the same HIPAA regulations and will only release minimal information required by your insurance carrier(s) in order for your claim(s) to be processed. You have the right to revoke this authorization by submitting a written notification to our office.

VITAE
INTEGRATIVE MEDICAL CENTER

I authorize Vitae Integrative Medical Center to discuss my personal health information, "PHI", with the following individuals:

1. _____ Relationship: _____

The above individual has permission to access my Vitae patient portal, which contains medical records, appointment information and other PHI: ***YES / NO***

2. _____ Relationship: _____

The above individual has permission to access my Vitae patient portal, which contains medical records, appointment information and other PHI: ***YES / NO***

☐ **I do not wish for Vitae Integrative Medical Center to discuss my personal health information with anyone.**

I have read and understand the above policies.

_____ _____

Signature of Patient, Guardian, or Legal Representative **Date Signed**

_____

Printed Name

Telephone: (907) 929 - 2222
Fax: (907) 929 - 2225

2925 Debarr Rd. Suite 150
Anchorage, AK 99508

www.vitaeheal.com