Notice of Privacy Practices

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📞 **(774) 297-2397**

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed, and how you can access this information. Please review it carefully.

Your Rights

When it comes to your health information, you have the right to:

✔ Get a copy of your paper or electronic medical record
✔ Request corrections to your medical record
✔ Request confidential communications
✔ Ask us to limit what we use or share
✔ Get a list of disclosures (who we've shared information with)
✔ Get a copy of this privacy notice
✔ Choose someone to act for you
✔ File a complaint if you believe your rights have been violated

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1. Get a Copy of Your Medical Record

- You may request an electronic or paper copy of your medical record and other health information we maintain.
- We will provide it within **30 days** of your request.
- A reasonable, cost-based fee may apply.

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2. Request a Correction

- You may request corrections to information you believe is incorrect or incomplete.
- We may deny your request, but we will provide a written explanation within **60 days**.

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3. Request Confidential Communications

- You may request that we contact you in a specific way (e.g., home phone, office phone) or send mail to a different address.
- We will honor all reasonable requests.

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4. Request Limits on Use or Sharing

- You may request limits on how we use or share your information for treatment, payment, or operations.
- We are not required to agree if it affects your care.
- If you pay out-of-pocket in full, you may request we not share that information with your insurer for payment or operations purposes. We will comply unless legally required otherwise.

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5. Get a List of Disclosures

- You may request a list of disclosures made in the past **six years**.
- This excludes disclosures for treatment, payment, healthcare operations, and certain other exceptions.
- One report per year is free; additional requests within 12 months may incur a fee.

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6. Get a Copy of This Notice

- You may request a paper copy at any time, even if you agreed to receive it electronically.

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7. Choose Someone to Act for You

- If you have a medical power of attorney or legal guardian, that individual may exercise your rights.

- We will verify their authority before taking action.

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8. File a Complaint

If you believe your rights have been violated:

- Contact us at **(774) 297-2397**
- Or file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights:
200 Independence Avenue, S.W.
Washington, D.C. 20201
📞 1-877-696-6775
🌐 www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you may tell us your preferences regarding sharing.

You have the right to request that we:

- Share information with family, close friends, or others involved in your care
- Share information in disaster relief situations
- Include your information in a hospital directory

If you are unable to communicate your preference (e.g., unconscious), we may share information if it is in your best interest or necessary to prevent a serious threat to health or safety.

We Never Share Without Written Permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Luna Hormone Health does not use patient information or images for fundraising or marketing unless you have been separately contacted and agreed to participate in a specific event.

We will never sell your information.

Our Uses and Disclosures

How We Typically Use or Share Your Information

Treatment - We may share your health information with professionals involved in your care.

Example: A doctor treating your injury consults another provider about your overall health.

Operations

We may use your information to run our practice, improve care, and contact you when necessary.

Example: Managing your treatment plan and services.

Billing

We may share your information with health plans, labs, or testing companies for payment purposes and/or insurance billing purposes.

Other Permitted Uses and Disclosures

We may use or share your information when required or permitted by law, including:

Public Health & Safety

- Preventing disease
- Reporting adverse medication reactions
- Reporting suspected abuse, neglect, or domestic violence
- Preventing serious threats to health or safety
- Assisting with product recalls

Research

We may use or share de-identified information for health research, as permitted by law.

Legal & Government Requests

- Compliance with state or federal laws
- Health oversight activities
- Workers' compensation claims
- Law enforcement requests
- Military, national security, or protective services
- Court orders, subpoenas, or administrative proceedings

Organ & Tissue Donation

We may share information with organ procurement organizations.

Medical Examiners & Funeral Directors

We may share information after death when required.

For more information:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

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Our Responsibilities

We are required by law to:

- Maintain the privacy and security of your protected health information
- Notify you promptly of any breach that may compromise your information
- Follow the practices described in this notice
- Provide you a copy of this notice

We will not use or share your information beyond what is described here unless you provide written permission. You may revoke permission at any time in writing.

For more information:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

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Changes to This Notice

We reserve the right to update this notice.
Any changes will apply to all information we maintain and will be available upon request and in our office.

Marketing Consent (Optional)

May we share positive feedback you provide during the program in our marketing materials?
Your identity will remain confidential.

☐ Yes
☐ No

Acknowledgment of Receipt

By signing below, you acknowledge that:

- You have received this Notice of Privacy Practices
- You have reviewed it
- You have had the opportunity to ask questions

Client Signature: _____

Print Name: _____

Date: _____
