Effective Date: April 15th, 2019

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed by Wellness Partners Hawaii Inc. ("WPH") and how you can get access to this information. **Please review it carefully.** Sign, date, and return the *Notice of Privacy Practices Acknowledgment* to WPH office staff to indicate receipt of this notice and acknowledge your understanding of the information which it contains.

CONTACT INFORMATION FOR WPH

Mailing Address:	P.O. Box 26062, Honolulu, HI 96825
Oahu Office (Main):	6700 Kalanianaole Hwy Suite 201. Honoolulu, HI 96825
Maui Office:	135 Wakea Ave., Suite 213, Kahului, HI 96732
Phone (call/text):	(808) 379-6656
Fax:	(808) 379-3750
Website:	https://www.wellnesspartnershawaii.com/

For specific inquiries or additional information related to WPH's privacy practices, feel free to contact Erik Kuo, at 808-379-6656.

YOUR RIGHTS	
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.	
Get an electronic or paper copy of your medical record.	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information with certain individuals, companies, or organizations for treatment, payment, or our operations.
	  ○ We are not required to agree to your request, and we may say "no" if it would affect your care. However, if we say "yes," then the restriction will be binding on us.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  ○ We will say "yes" unless a law requires us to share that information.

YOUR RIGHTS (continued)	
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has the authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the contact information for WPH listed above. • You can file a complaint with the U.S. Department of Health and Human Services Offices for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.
Revoke your authorization	• You may revoke any of your authorizations at any time; however, such revocation must be in writing and will only apply to actions taken after we receive your written revocation.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation If you are not able to tell us your preference, for example you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes

OTHER USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	**Example:** Referral to another health care provider or hospital to diagnose, assess, or treat your health condition.

OTHER USES AND DISCLOSURES (continued)		
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	**Example:** We use health information about you to manage your treatment and services.
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	**Example:** We give information about you to your health insurance plan so it will pay for your services.

Are there any privacy exceptions commonly applicable to mental health clinics? In general, we can only release health information about you to others with your written permission. However, certain situations would legally require us to take action that might necessitate revealing information about your treatment.

Abuse	• If we believe that a child, elderly person, or disabled person is being abused, we may be required to file a report with the appropriate state agency.
Threat of Serious Bodily Harm to Others	• If we believe that a client is threatening serious bodily harm to another person, we may be required to take protective actions, including notifying the potential victim, notifying the police, or arranging for hospitalization.
Threat of Serious Bodily Harm to Oneself	• If you threaten to harm yourself, we may be required to seek hospitalization for you or to contact your family members or others who can help provide protection.
Judicial Proceedings	• If a Judge orders a provider to offer testimony because resolution of certain issues demands it, then we would make every effort to fully discuss it with you before taking any action.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share information about you for certain situations such as: ○ Preventing disease ○ Helping with product recalls ○ Reporting adverse reactions to medications
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ○ For workers' compensation claims ○ For law enforcement purposes or with a law enforcement official ○ With health oversight agencies for activities authorized by law ○ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

RIGHTS OF MINORS

If you are under 18 years of age, we will generally treat your parent, guardian, or other person with legal authority to act on your behalf as your personal representative. We must provide your personal representative with access to your health information.

If an individual other than your parent is authorized to provide consent to your treatment and provides such consent, we will not treat your parent as a personal representative. If your parent agrees to a confidential relationship between you and us with respect to your mental health treatment, we will not treat your parent as a personal representative. In some instances, Hawaii law allows a minor who is 14 years of age or older to consent to receiving mental health treatment or counseling services. If you will be receiving treatment under these circumstances and you do not request your parent to be treated as a personal representative, then we will not treat your parent as your personal representative.

At all times, in the interest of your safety, we will exercise our professional judgment in determining whether it is in your best interest to treat a family member, legal guardian, or other person involved in your care as your personal representative. This includes using our discretion to determine whether it is appropriate to provide or deny such individual(s) access to your health information.

OUR RESPONSIBILITIES

- We and all of our employees are required by federal and state laws to maintain the privacy and security of your protected health information.
- In all cases involving the disclosure of your protected health information, we will share only the minimum necessary information required.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We will only release records generated and developed through WPH. We will not release any records received from another provider. It is your responsibility to acquire records from the provider who generated such records.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticeapp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information ("PHI"). As a client of Wellness Partners Hawaii Inc. ("WPH"), I understand that my PHI can and will be used by WPH to:

- Conduct, plan, manage, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal health care operations such as quality assessments.

I have received, read, and understand WPH's *Notice of Privacy Practices*, which contains a more complete description of the ways in which WPH may use and disclose my PHI. I understand that WPH has the right to change its *Notice of Privacy Practices* from time to time and that I may contact WPH at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that WPH does not need to, but may choose to obtain my consent prior to disclosing my PHI for treatment, payment, or operations purposes. I may request in writing that WPH restrict how my PHI is used or disclosed. I also understand that WPH is not required to agree to my requested restrictions, but if it does agree then it must abide by such restrictions.

Client Signature	Date:
Parent/Guardian Signature	Date:
Print Name	
Relationship to Client (if applicable)	

OFFICE USE ONLY

I attempted to obtain the client's signature to acknowledge receipt of WPH's *Notice of Privacy Practices*, but was unable to do so for the reason(s) documented below.

Date:	Initials:	Reason(s):