Privacy Policy Notice

The purpose of this notice is to describe:

a) How medical information about you may be used and disclosed by Holistic Healthcare Services, Inc. and
b) How you can get access to your medical information if necessary.

Please review this form carefully and sign at the bottom.

The privacy of you medical information is important to our practice. Your information is personal and we agree not to disclose it to any other parties without your written consent, unless required by a Subpoena or Court Order.

Your records will remain with our office unless we receive a signed written request from you to forward them to another location. Consent forms are available from HHS, Inc. upon request. Any written authorization to forward records can be revoked in writing at any time unless records have already been sent. As a courtesy, there is no charge for the first request for your records to be forwarded. Additional requests are charged at a $.25 per page fee plus actual postage plus a $20 clerical fee as allowed by the Board of Registration in Medicine regulations.

For Insurance cases, it may be necessary for us to forward billing or treatment information in order for your claim to be processed. Your signature on the Consent and Record of Disclosure allows our office to release such information as needed. This authorization can be revoked in writing at any time. We will bill insurance or attorney's offices directly for reports or records requests made by their offices.

All staff members sign an employment contract agreeing to keep all patient information confidential. Employees have access to information on a need to know basis only.

If you have any questions, please contact our Privacy Officer: Barbara April, Office Manager, Holistic Healthcare Services, Inc., 21 Everett Avenue, Belchertown MA 01007, (413) 323-4773

	May we leave a message and/or medical info?	Which number is primary for messages?
Phone (Home) _____	**Y / N**	____
(Work) _____	**Y / N**	____
(Cell) _____	**Y / N**	____

Do you have an email address? **Y / N** (if yes, please print clearly):_____

May we contact you at that email address, possibly with medically sensitive details? **Y / N**

Please list all people that we may speak to about you and your medical status:

Name: _____ Phone # _____ Relationship to patient: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Signature Print name Date

Please turn this page over and complete the other side.