



HANDS ON HEALING

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED, AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION.

LEGAL DUTY:

JOHN LEONARD, PT, LMBT and Hands-On Healing, LLC is required by law to protect the privacy of your personal health information, provide this notice about my information practices, and follow the information practices below.

USES AND DISCLOSURES OF HEALTH INFORMATION:

JOHN LEONARD, PT, LMBT and Hands-On Healing, LLC may:

- Use or disclose your personal health information for providing physical therapy and massage therapy services for treatment, and for obtaining payment for services.
- Use or disclose your personal health information without prior authorization for purposes of public health, auditing, emergencies, and when required by law. Any other use of this information requires your written authorization.

PATIENT'S RIGHTS:

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request a correction of any inaccurate or incomplete information in your records. You also have the right to request a list of the instances that your personal health information has been disclosed for reasons other than treatment, payment, or administrative purposes.

If you have given written authorization to provide your personal health information for any reason other than the above, you may revoke this in writing at any time.

You have the right to restrict how your personal health information is used and disclosed for treatment, payment, and administrative operations if you notify John Leonard PT, LMBT and Hands-On Healing, LLC in writing. John Leonard, PT, LMBT and Hands-On Healing, LLC is not required to agree to the requests for restrictions.



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You have the right to restrict disclosures to a health plan concerning treatment if you have paid for services by John Leonard, PT, LMBT out of pocket and in full.

HIPPA PRIVACY NOTICE: A full copy is available upon request.

BY SIGNING BELOW I give John Leonard, PT, LMBT and Hands-On Healing, LLC permission to:

- Use or disclose your personal health information for providing physical therapy and massage therapy services for treatment, and for obtaining payment for services.
- To contact you at the phone numbers you provide, and to leave a message if you do not answer.
- To contact you at the email address you provide to discuss your care.

PATIENT'S NAME: _____(printed)

PATIENT'S SIGNATURE: _____

DATE SIGNED: _____