

## Cascade Health Massage – Patient Rights

Health care providers are required by law to maintain the privacy and security of protected health information (PHI). PHI includes individually identifiable information about your past, present or future health or condition; the provision of health care to you; information we create or receive about your health care; includes medical and personal records (i.e. social security number, address, phone number, etc.); financial information; and payment information.

Your PHI is never sold or used for marketing or other purposes without your permission. Examples of how CHM may disclose your information without your written permission:

- To person with medical responsibility for your care
- To administer your health benefits policy or contract
- To bill you for health care we provide
- When CHM is required to do so by state and federal law, including workers' compensation laws
- To an authorized public health authority or individual
- To government entities authorized to receive reports regarding abuse, neglect or domestic violence
- To health oversight agencies for certain activities such as audits, examinations, investigations, inspections and licensures
- To law enforcement officials in limited circumstances for law enforcement purposes
- To communicate with you about appointment reminders, treatment services, options or alternatives as well as health related benefits or services that may be of interest to you
- To avoid a serious threat to the health or safety of yourself and others

These are your rights:

- Request restrictions by asking that we limit the way we use or disclose your PHI for treatment, payment or health care operations. You may ask us to limit the information we give to someone who is involved in your care such as a family member. We will honor any such limits unless it is an emergency situation.
- Restrict disclosures of PHI to a health plan regarding your health care when you have paid out of pocket.
- Receive confidential communications of PHI.

By signing below, I acknowledge I have received Cascade Health Massage's notice of privacy practices and patient rights.

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Client Printed Name

Signature

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Date

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Parent/Guardian Printed Name

Signature

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Date