

KAILO COUNSELING

LIFESTYLE CHANGE AND
NUTRITIONAL COUNSELING
MARRIAGE, FAMILY AND
INDIVIDUAL COUNSELING



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HIPAA Privacy Act

The following describes how medical information about you may be used and disclosed and how you can get access to this information. I am required by the Federal government to provide you with this information. I apologize for its length, but please review it carefully.

I, _____, understand that Kailo Counseling is required by law to maintain the privacy of any confidential information on me or my case. I have received this statement because Kailo Counseling is required by law to provide it. My information will be used only for the purposes of treatment, payment and health care operations. Without my written consent (or that of my representative), it will not be shared with ANYONE outside the practice (including family members) unless subpoenaed by a court of law or required by your insurance company. This consent may be revoked at any time.

I understand that from time to time, I will receive calls from Kailo Counseling regarding appointment reminders, information about treatments, and other health-related benefits and services that may be of interest to me.

I understand that I have the right to request restriction of uses and disclosures of my information by Kailo Counseling, however, if the restrictions are too extreme, Kailo Counseling may not accept me as a client.

I understand that I may request copies of items in my file, but I must do so in writing. I also understand that Kailo Counseling may refuse my request if:

- there is reference to another person who is also protected under these rules of confidentiality
- the requested item might cause substantial harm to me or another person.

I understand that I have the right to ask to amend my medical file if I feel it is inadequate or incomplete.

I have the right to receive an accounting of any disclosures of my personal information for 6 years beginning 04/14/2003. However, I understand that there are certain circumstances that may not be documented. If disclosures are made:

- to carry out treatment, payment and health care operations;
- to me or my representative;
- as a result of signed authorization;
- to persons directly involved in my care at Kailo Counseling;
- for national security or intelligence purposes; or
- to correctional institutions or law enforcement officials.

Kailo Counseling reserves the right to change the terms of this privacy policy and make new provisions effective for all confidential information it maintains. Should Kailo Counseling make any changes to this policy, I understand I will be contacted in writing and be required to sign an updated or changed version of the policy.

I understand that I can contact the Secretary of the U.S. Department of Health and Human Services without fear of retaliation if I believe my privacy rights have been violated.

Date: _____

Printed Name: _____

Signature: _____

Or, Representative: _____

(We must have documentation on file that this person is your legal representative.)

Signature: _____

In order for your file to be considered complete by law, it must contain a signed and dated copy of this agreement.