

# The Centered Body, PC Privacy Notice (Summary)

**THIS NOTICE DESCRIBES A SUMMARY OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. A FULL PRIVACY NOTICE WILL BE PROVIDED TO EACH INDIVIDUAL SEEKING TREATMENT OR SERVICES AT THIS ESTABLISHMENT.**

The Centered Body, PC (TCB) is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from us. The creation of a record detailing the care and services you receive helps the staff and providers of TCB to provide you with quality health care. This Privacy Notice details how your PHI may be used and disclosed to third parties and also details your rights regarding your PHI.

## **CONSENT**

TCB may use and/or disclose your PHI provided that TCB first obtains a valid Consent signed by you. The Consent will allow TCB to use and/or disclose your PHI for the purposes of:

- a) Treatment
- b) Payment
- c) Health Care Operations

## **NO CONSENT REQUIRED**

TCB may use and/or disclose your PHI without a written Consent from you in the following instances:

- a) De-identified Information
- b) Business Associate
- c) Personal Representative
- d) Emergency Situations
- e) Communication Barriers (or inability to Communicate)
- f) Public Health Activities
- g) Abuse, Neglect, or Domestic Violence
- h) Health Oversight Activities
- i) Judicial and Administrative Proceeding
- j) Law Enforcement Purposes
- k) Coroner or Medical Examiner
- l) Research
- m) Avert a Threat to Health or Safety
- n) Specialized Government Functions
- o) Worker's Compensation
- p) National Security and Intelligence Activities
- q) Military and Veterans

## **APPOINTMENT REMINDERS OR OTHER TELEPHONE, MAIL, ELECTRONIC COMMUNICATIONS**

## **FAMILY/FRIENDS (Pursuant to your authorization to do so)**

## **AUTHORIZATION (other situation-specific use or disclosure pursuant to your authorization to do so)**

## **YOUR RIGHTS**

You have the right to:

- a) Revoke any Authorization and/or Consent, in writing, at any time
- b) Request restrictions on certain use and/or disclosure of your PHI as provided by law.
- c) Receive confidential communications or PHI by alternative means or at alternative locations.
- d) Inspect and copy you PHI as provided by law.
- e) Amend your PHI as provided by law.
- f) Receive and accounting of disclosures of your PHI as provided by law.
- g) Receive a paper copy of the full Privacy Notice (this is Summary) from TCB.
- h) Complain to Dr. White or to the Secretary Health & Human Services (HHS) if you believe your privacy rights have been violated.
- i) To obtain more information on, or have your questions about your rights answered, you may contact Dr. Strange at (770) 936.9707 or via email at [tcb.frontdesk@gmail.com](mailto:tcb.frontdesk@gmail.com)

## **THE CENTERED BODY, PC REQUIREMENTS**

The Centered Body, PC:

- a) is required by federal law to maintain the privacy of your PHI and to provide you with a full copy of the Privacy Notice;
- b) is required to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law where state and federal laws conflict, and where state law is more stringent in the area of privacy;
- c) is required to abide by the terms of our Privacy Notice;
- d) reserves the right to change the terms of the Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that TCB maintains;
- e) will distribute any revised Privacy Notice to you prior to implementation of such; and
- f) will not retaliate against you for filing any complaint.

**THE CENTERED BODY, PC  
NOTICE OF PRIVACY POLICY  
ACKNOWLEDGEMENT**

**I HAVE READ THE CENTERED BODY, PC PRIVACY NOTICE, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT ME MAY BE USED AND DISCLOSED, AND HOW I CAN GET ACCESS TO THIS INFORMATION. I UNDERSTAND MY RIGHTS CONTAINED IN THE NOTICE.**

**By way of my signature below, I provide The Centered Body, PC and/or Dr. Mary M. Strange, with my authorization and consent to use and disclose my protected health information for the purpose of treatment, payment, and healthcare operations as described in the Privacy Notice.**

\_\_\_\_\_  
**Patient Name (Print)**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Facility Signature**

\_\_\_\_\_  
**Date**

OFFICE USE ONLY

FILE #: \_\_\_\_\_