KUMUKAHI
HEALTH + WELLNESS

HIPAA NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health and personal information (PHI) to carryout treatment, payment, or business operations and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected information. Protected health/personal information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health/Personal Information

   Uses and Disclosures of PHI: Your protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to support business operations of this office, if requested by you to a finance company to pay for your care, and any other use required by law.

   Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health/personal information, as necessary, if you require treatment by a different specialist. Your PHI may be provided to another clinic or clinician to whom you have been referred to ensure that the physician has the necessary information to treat you.

   Payment: Your PHI will be used, if requested, to obtain payment for your health care. For example, we may be required to disclose pertinent PHI to obtain insurance approvals or to get you into a compassionate use medication program.

   Healthcare Operations: We may use or disclose, as is necessary, your protected PHI in order to support the clinical and business activities of this office. These activities include, but are not limited to; quality assessment activities, employee review activities, and licensing. In addition, we may also call you by your first name in the waiting room in order to identify you. We may also use your PHI to contact you to remind you of upcoming appointments or to discuss your healthcare.

We may use or disclose your PHI in the following situations without your authorization including but not limited to: public health issues as required by law, communicable diseases, health oversite; abuse or neglect; Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, research, criminal activity and national security, inmates, required uses and disclosures. Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine out compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected HPI.

You have the right to require a restriction of your PHI. This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment or healthcare operations. You may also request that any part of your HPI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restrictions to apply.

We are not required to agree to a restriction that you may request. If our Clinical Director and Executive Director believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another service provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to a paper copy of this notice upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to amend your protected PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and with provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may issue a complaint directly to us or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on July 22, 2020.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health/personal information. If you have any objections to this form, please ask to speak with our HIPPA compliance officer in person or by phone.

Contact Missy Kunimitsu: (808) 982-8800

By signing below, I acknowledge and certify that I, _____ have read and understand this privacy agreement and that I am signing it voluntarily.

Patient Signature and date

Signature of legal guardian if patient is under the age of 18, and date