

admitted to participation in a crime or has escaped from lawful custody.

## Client Rights

**Access:** You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, I will charge you **25¢** for each page to copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that I send it to you or another party in electronic form. If you prefer, I will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of my fee structure.

**Accounting of Disclosures:** You have the right to receive a list of instances in which I or my business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, my duty to provide an accounting only covers disclosures after July 1, 2019 and only applies to disclosures for the three (3) years preceding your request. I will provide you with the date on which I made the disclosure, the name of the person or entity to whom I disclosed your protected health information, a description of the protected health information I disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of my fee structure.

**Restriction Requests:** You have the right to request that I place additional restrictions on my use or disclosure of your protected health information. Except as noted

herein, I am not required to agree to these additional restrictions, but if I do, I will abide by my agreement (except in an emergency). I am required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service I provide to you. Any agreement I may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on my behalf. I will not be bound unless my agreement is so memorialized in writing.

**Confidential Communication:** You have the right to request that I communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. I must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

**Amendment:** You have the right to request that I amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request if I did not create the information you want amended or for certain other reasons. If I deny your request, I will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If I accept your request to amend the information, I will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

**Electronic Notice:** If you receive this notice on my website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

**Notice of Unauthorized Disclosures:** If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

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## Questions and Complaints

If you want more information about my privacy practices or have questions or concerns, please contact us using the information below.

If you believe that I may have violated your privacy rights, or you disagree with a decision I made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S.

Department of Health and Human Services. I will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

I support your right to protect the privacy of your protected health information. I will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: **Emily Campbell**

Telephone: **(402) 885-5090** Fax: **(402) 575-9539**

Address: **4611 S. 96<sup>th</sup> St, Ste. 251, Omaha, NE 68127**