VITAL BRIDGE
WELLNESS

Privacy and Sharing of Information

Last reviewed July 2026.

Notice of Privacy Practices

This Notice of Privacy Practices ("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.

I. Our Commitment to Your Privacy

Vital Bridge Wellness is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our healthcare activities, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required to provide you with this Notice of our legal duties and privacy practices concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

II. How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

1. **For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other healthcare personnel who are involved in taking care of you.
2. **For Payment:** We may use and disclose medical information about your treatment and services to bill and collect payment from you or a third party payer.

3. **For Healthcare Operations:** We may use and disclose medical information about you for operational purposes. These uses and disclosures are necessary to run the organization and make sure that all of our patients receive quality care.

III. Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

1. **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care or payment for your care. This includes medical and billing records.
2. **Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information.
3. **Right to an Accounting of Disclosures:** You have the right to request an accounting of certain disclosures we made of medical information for purposes other than treatment, payment, and healthcare operations.
4. **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations.
5. **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

IV. Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

V. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Contact Information

For further information about the matters covered by this Notice, please contact: Cathy Lunsford at cathy@vitalbridgewellness.com.

"I, _____, hereby acknowledge that I have received and reviewed Vital Bridge Wellness's Notice of Privacy Rights. I understand the information provided in the notice regarding the protection and use of my personal health information, as well as my rights as a patient under applicable healthcare privacy laws and regulations."

_____

[Patient Signature]

Date: _____

V. 1/effective 10/15/2024

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Client Signature Date

Print Name