Sara Ohgushi, N.D.

Naturopathic Physician & Midwife
2207 NE Broadway, Suite 200, Portland, OR 97232
503-236-6006 fax 503-232-3436 Email drsara@sarasfamilycare.com

Notice of Privacy Practices
HIPAA
(Health Insurance Portability & Accountability Act)

I, Sara Ohgushi ND, respect and am vigilant in protecting patient confidentiality and the privacy of your health information. I am also required by law to maintain the privacy of your protected health information, to provide you with this notice and to abide by its terms. This notice explains how your medical information may be used and shared with others involved in your health care. It also informs you about your rights as my valued customer and provides information about exercising those rights. ***If your child is my patient, all of these same policies apply to your child's health information.***

How I share information

The following are ways I may use or share information about you:

For Treatment: I may share your information with other staff members, midwives, laboratories, technicians, physicians or other health care workers to help them provide medical care to you. For example, I might consult with an MD regarding you or your child's health. If you are transferred to a hospital during labor I may give them access to any medical records I hold that would assist them in providing you with needed health care.

For Office operations: I may use or disclose your health information in order to run the office efficiently and ensure that you receive quality care. For example, I may have office personnel contact you as a reminder that you have an appointment. Office personnel may also use your information to contact another provider office to initiate consultations, arrange appointments or otherwise assist me with managing your health care. I may use your health information to evaluate the performance of my staff in caring for you. I may report information to state and federal agencies that regulate me, such as the Oregon Board of Naturopathic Medicine. Also, I must give the state Vital Records department information about you in order for me to file a birth certificate if I attend the birth of your baby.

For Payment: I will use your information to make claims to your insurance carrier to collect payment for medical bills which are covered by your health plan benefits. I may also share your information with individuals who perform business functions for me, such as billing services. I will only share your information if there is a business need to do so and if my business partner agrees to protect the information.

If I use or disclose your information for any reasons other than the above, I will first get your written permission. If you give me written permission and change your mind, you may revoke it in writing at any time. I will honor the revocation from that date forward with the exception of already disclosed information based on your previous permission.

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Special Situations

There are special situations that may require me to release your health information to others.

Required by Law: I will disclose health information about you when required to do so by federal, state or local law.

Law Enforcement: I may be required by a court or administrative agency to provide information because of a search warrant or subpoena.

Public Health or Safety Risks: I may report health information to public health agencies if I believe there is a serious health or safety threat to you or the public. For example, I am required to report when I believe there has been child abuse or neglect or domestic violence that threatens you or your child's health.

Information Not Personally Identifiable: I may use or disclose health information about you in a way that does not personally identify you or reveal who you are. For example, in the preparation of birth statistics for organizations such as the Midwives Alliance of North America or in state mandated peer review.

Family and Friends: I may disclose health information about you to your family members or friends if I obtain your written or verbal agreement to do so or if I can infer from the circumstances, based on my professional judgement that you would not object. For example, I may assume you agree to my discussing your personal health information in the presence of your spouse, friend or family member when you bring them with you into the room during an office visit or during labor and delivery. I may, using my professional judgment, assume that it is in your best interest to disclose to another family member or friend when you are not capable of giving consent due to incapacity or when you are not present for other reasons such as transfer to the hospital. In that situation, I will disclose only health information relevant to the person's involvement in your care or emotional needs. For example, I may provide updates on your progress to a person who accompanies you to the hospital. I may determine that it is in your best interest to allow another person to act on your behalf by picking up filled prescriptions or supplies or to contact other people in your identified network of support.

Cord Blood Collection (or other organ and tissue donation): When you have pre-arranged for cord blood collection I may release health information to organizations that handle the procurement or to any other organizations necessary to facilitate pre-arranged donations.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, I may be required by military command or other government authorities to release health information about you. This also applies to foreign military personnel in this country and required reports to foreign military authorities.

Workers' Compensation: I may report health information on job-related injuries because of the requirements of your state worker compensation laws.

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Incidents of Loss: In the very rare cases where there is fetal death during pregnancy or other death, information may be disclosed to Coroners and Medical Examiners to procure a death certificate and as part of investigations and to funeral directors to assist with making funeral arrangements.

If I use or disclose your information for any reasons other than the above, I will first get your written permission. If you give me written permission and change your mind, you may revoke your written permission at any time. I will honor the revocation except to the extent that I have already relied on your permission. Note: If I disclose information as a result of your written permission it may be re-disclosed by the receiving party and may no longer be protected by state and federal privacy rules.

Your rights regarding your Health Information

You have certain rights with respect to your protected health information. These include:

Restrictions of Disclosure: You have the right to ask us to restrict how I use or disclose your information for treatment, payment or healthcare operations. You also have the right to ask me to restrict what information I may give to persons involved in your care. While I may honor your request for restrictions, I am not required to agree to these restrictions. Federal or state law may restrict re-disclosure of additional information such as HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, and treatment or referral information without your written consent.

Confidential Communications: You have the right to submit special instructions to me regarding how I send information to you that contains protected health information. For example, you may request that I send your information by U.S. Mail only to a specified address or to call a specific phone number. I will accommodate reasonable requests. You are not required to give me the reason for your request. However, I may require that you make your request in writing.

Inspection and Copies: You have the right to inspect and obtain a copy of your health information. I may charge you a fee for the costs of copying, mailing or other supplies. You may not be permitted to inspect or obtain a copy of information that is:

-contained in psychotherapy notes;

-compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding.

-sent to me by other health care providers. In most cases you must obtain those records directly from the health care provider who generated them.

I may deny your request to inspect or copy records in certain limited circumstances. You may ask that any denial be reviewed. If the law gives you a right to have my denial reviewed, I will select a licensed healthcare professional to review your request and my denial. The person conducting the review will not be the person who denied your request, and I will comply with the outcome of the review.

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Amendment of Records: If you believe the health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, please submit it in writing. I may deny your request for an amendment if it does not include a reason to support the request. If I deny your request to amend, I will notify you of the reason for the denial. You have the right to file a written statement of disagreement. I have a right to rebut your statement. However, you have the right to request that your written request, my written denial and your statement of disagreement be included with your information for any future disclosures. I may deny your request if you ask me to amend information that:

1. I did not create (unless the person or entity that created the information is no longer available to make the amendment themselves).
2. Is not part of the health information that I keep
3. You would not be permitted to inspect and copy
4. Is accurate and complete.

Disclosures: You have the right to receive an accounting of certain disclosures of your information, if any, made by me during the six years prior to your request. The accounting may not include allowable disclosures already noted above.

If, at any time my practice were to participate in a research trial, I would not disclose your information without a waiver of authorization from you. Once authorized, I may not account for each separate disclosure of your information. Instead, I will provide you with the following: 1. The name of the researching body. 2. A description of the research protocol or activity including the purpose for the research and the criteria for selecting particular records. 3. A description of the type of protected health information that was disclosed. 4. The date or period of time when such disclosure occurred. and 5. The name, address, and telephone number of the entity that sponsored the research and researcher to whom the information was disclosed.

You have a right to receive a paper copy of this notice upon request at any time. Should any of my privacy practices change, the terms of this notice may change. Once revised, I will notify you that a change has been made if you are still in my current care.

If you have any questions about this notice, please contact me by calling my office number or by email and your call or email will be returned within 2 business days. You have the right to file a complaint with me if you believe your privacy rights have been violated. I will not retaliate against you for filing such a complaint. If you feel my response is unsatisfactory you may also file a complaint with the Oregon Board of Naturopathic Medicine or the Washington State Department of Health.