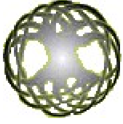

Su Fairchild MD / Alliance Integrative Medicine LLC
PO Box 974, Bloomsburg, PA 17815
Phone: 703-828-4485 / Fax: 888-414-5264

Notice of Privacy Practices

Dr Fairchild is committed to the highest standards of privacy.

Your information will never be shared with any database or fundraising company.

Since we do not bill insurance, we will not share your information with any insurance company except in certain instances to assist with or expedite your medical care (for example, filling out pre-auth forms, or giving them enough reasons so they will pay for certain testing or medication).

We do not share information with your employer or utility company except at your request.

We will not share your information with your family or friends unless you give us permission.

We may share or discuss your health information with other professionals who are also legitimately involved in your care, for the purposes of coordinating treatment and/or improving your care.

We may share your information in certain public health and safety issues such as diseases reportable by law, assisting with product recalls, reporting adverse reactions to medication, reporting suspected abuse, or to comply with the law. In such cases, only the minimum information required is shared, and to the minimum number of people.

We might use your medical case for research or marketing purposes, but if so, will remove any and all information, such as your name, date of birth, etc, that could personally identify you.

Your Rights
You have the right to get a copy of your medical record (a copy or summary will usually be provided within 30 days of your request; a reasonable fee may be charged for extensive records), make corrections to your medical record, request confidential communication by asking for specific ways of communication (eg, cell phone, email, etc), ask us to limit the information we share, ask us to share information with a family member or a friend involved in your care, ask us to share your information in a disaster relief situation, get a list of those with whom we've shared your information, get a paper copy of this privacy notice, choose someone to act for you, file a complaint if you believe your privacy rights have been violated.

Our Responsibilities
We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Acknowledgement of receipt (to be signed by patient or representative)

___ (initial) I acknowlegde that I was provided with a copy of the above Notice of Privacy Practices.

Patient name ______________________________________

____ ______________
Signature (to be signed by patient or representative) Date