



Chuck Graham, M.Ac.

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Privacy Practices Notification

In compliance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, I would like to inform you of my Privacy Practices. These practices are directed at protecting the privacy of your treatments and medical information. My privacy practices insure that:

1. All patient records are stored in a secured area.
2. You have the right to review your chart. Should you like to review your chart I request that you make an appointment to do so.
3. Your medical information is private. I am unable to discuss your treatment or provide medical information or records with anyone without your explicit written consent.
4. Information shared with your insurance company will only be information required to secure payment for our services. This information may include your name, diagnosis, CPT code, dates of service, treatment fees. If your insurer requires more information, they must obtain your consent before I will share the requested information.
5. If we decide to order an herbal formula for you from an herbal company, the herb company will receive only the information necessary to complete your herbal formula, bill it and send it to you.
6. Should you like me to speak with another of your health care providers, you must sign a Release of Information form in order to allow me to provide information to anyone.
7. You may review the Privacy Practices Policy at anytime, though I request that you make an appointment to do so.
8. If I am unavailable to treat you, and you request another acupuncturist to treat you, the substitute practitioner will have access to your chart for the sole purpose of treating you.
9. Information about your treatment may be discussed with other acupuncture practitioners for the purpose of education and peer review. Under these circumstances, your name will not be disclosed.

In signing below I acknowledge receipt of the Privacy Practices Notification for Chuck Graham, M.Ac.

Patient Name (please print)_____

Patient Signature_____ Date_____