HIPAA Notice of Privacy Practices

You authorize Vita Health, PLLC, it's affiliates, employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims, health benefit coverage issues and coordinate care.

You understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

You understand that you have a right to revoke this authorization by providing written notice. However, this authorization may not be revoked if Vita Health employees or agents have taken action on this authorization prior to receiving written notice. You also understand that you have a right to have a copy of this authorization.

You understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

You further understand that this authorization is voluntary and that you may refuse to sign this authorization. Your refusal to sign will not affect your eligibility for benefits or enrollment or payment for or coverage of services.