MZ CustomFit & Authorized Business Partners
125 Commerce Park Road Suite 105 Mooresville, NC 28117
(833) 488-1905 (Phone) **(877) 890-7749 (Fax)**

Notice of MZ CustomFit's Policies and Practices to Protect the Privacy of Your Health Information

THIS 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.

MZ CustomFit is committed to protecting your privacy and understands the importance of safeguarding your medical information. We are required by federal law to maintain the privacy of health information that identifies you or that could be used to identify you (know as "Protected Health Information" or "PHI"). We are also required to provide you with this Notice of Privacy Practices, which explains our legal duties and privacy practices, as well as your rights, with respect to PHI that we collect and maintain. MZ CustomFit is required by federal law to abide by this Notice. MZ CustomFit abides by the terms of this Notice currently in effect and reserves the right to revise or maned the notice as needed.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, Health Care Operations, and Sale of the Business"
    - Treatment is when I provide, coordinate or manage your health care and other services related to your health. An example of treatment would be when I consult with another health care provider, such as your family physician or therapist.
    - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and aministrative and case management and care coordination.
    - "Use" applies to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
    - "Disclosure" applies to activities outside of my office [office, clinic, practice group, etc.], such as releasing, transferring or providing access to information about you to other parties.

II. Uses and Disclosures for Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information.

We must obtain your written authorization to use and disclose your PHI for most marketing purposes.

We must obtain your written authorization for any disclosure of your PHI which constitutes a sale of PHI.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Abuse or Neglect**: If you have been a victim of abuse, neglect, or domestic violence, we may disclose your PHI to a government agency authorized to receive such information. In addition, we may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect.
- **Serious Threat to Health or Safety**: We may disclose your PHI if we believe it is necessary to prevent a serious and imminent threat to the public health or safety and it is to someone, we reasonably believe is able to prevent or lessen the threat.
- **Health Oversight**: We may disclose of your PHI to health oversight agencies for activities authorized by law, including surveys, audits, and compliance inspections.
- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made about the professional services, I provided you or the records thereof such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is that case.
- **Law Enforcement**: We may disclose your PHI, so long as applicable legal requirements are met, for law enforcement purposes, such as providing Coroners and Funeral Directors. We may disclose your PHI to a coroner, medical examiner, or funeral director if it is needed to perform their legally authorized duty.
- **Organ Donation**: I you are an organ donor; we may disclose your PHI to organ procurement organization as necessary to facilitate organ donation or transplantation.
- **Workers' Compensation**: if you file workers' compensation claim, I am required by law to provide all existing information compiled by me pertaining to the claim to your employer, the insurance carrier, their attorneys.

- **Business Associates**: We use many outside contractors that work with MZ CustomFit customers. These contractors are responsible for financial aspects of the business as well as insurance processing. These contractors are properly trained in protecting your PHI and following the guidelines of the law.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- *Right to Request Restrictions*- You have the right to request restrictions on certain uses and disclosures of protected health information about you.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- *Right to Inspect* – You have the right to inspect and copy your health care record.
- *Right to Amend*- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record.
- *Right to an Accounting*- You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy*- You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.
- *Right to Revoke* – You have the right to revoke your authorization to use or disclose PHI, expect when that action has already been taken.
- *Right of Notification* – You have the right to be notified if you are affected by a breach of unsecured PHI.

Provider's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will discuss them with you or mail the revisions to you.
- Accommodate request you may have with communication of PHI by alternative means.

V. Questions and Complaints

Cash patients that pay for their services out of pocket can demand that their PHI is not disclosed to the patient's third-party payor since a claim was never processed.

If you believe that we have violated your privacy rights, you may file a complaint with us by notifying our Privacy Officer in writing at the following address:

MZ CustomFit
PO Box 4837
Mooresville, NC 28117
Attn: Corporate Compliance, Privacy Officer
Phone: 704-799-2873

We will not retaliate against you in any way for filing a complaint. You may also submit your complaint to the Secretary of Health and Human Services.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This is a revision of the notice that was first published and effective July 1, 2003.

This notice is effective on May 25, 2021.

If you would like a paper copy of this Notice of Privacy Practices, please request one. This Notice of Privacy Practices is also available at www.mzcustomfit.com.

YOU HAVE A RIGHT TO REQUEST A COPY OF THIS FORM AFTER YOU SIGN IT

Patients Name : _____ Patients Signature : _____

Date : _____

If this authorization form is signed by a Personal Representative of the patient, please complete:

Representative's Name: _____ Representative Signature: _____

Date: _____

Relationship to Patient: _____

MZ CustomFit

MZ CustomFit Fitter Service Centers

Wellness Source, Inc. 125 Commerce Park Rd. Suite 105, Mooresville, NC 28117 • Survivor Gals - 3000 Cluster Rd., Unit 190, Plano, TX 75075 • Survivor Gals - 1400 8th Ave., Fort Worth, TX 76104 • Close to You - 11661 Preston Rd. #154, Dallas, TX 75230 • That Special Woman - 2461 N Reynolds Rd, Toledo, OH 43615

Authorization to Disclose Patient Health Care Information

_____ _____

(print full name of the patient) (patient's date of birth)

_____ _____

(address, city, state, zip) (phone number)

Authorization For Use or Disclosure of Health Information to MZ CustomFit & Business Associates:

_____ located at: _____

(physician, clinic, other) (address, city, state, zip)

_____ located at: _____

(physician, clinic, other) (address, city, state, zip)

_____ located at: _____

(physician, clinic, other) (address, city, state, zip)

INFORMATION TO BE RELEASED: For the following dates: _____ TO_____

____ All clinical records ____ Other (Specify): _____

PURPOSE OF/NEED FOR DISCLOSURE IS:

____ Additional Medical Care ____ Insurance Claim ____ Other (specify): _____

I authorize release of my medical records as listed above and understand that my authorization will remain in effect unless I cancel by written notice.

_____ _____

(patient/legal guardian signature) (date)