

BACK TO HEALTH CHIROPRACTIC CENTER

PRIVACY CONFIDENTIALITY STATEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

DISCLOSURE OF INFORMATION

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or health operations. Additional disclosures may be necessary to comply with Workers' Compensation and Public Health Laws as well as Judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by telephone or mail in the event a request for information is made.

APPOINTMENT REMINDER

The office may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders used by this office are: a) telephoning your home or work and leaving a message on your answering machine or with the individual answering the phone; and b) a postcard mailed to you at the address provided by you.

SIGN-IN LOG

The office maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office. This information may be seen by, and is accessible to, others who are seeking care or services in the office.

PATIENT PICTURES

The office maintains pictures of all willing patients. These pictures are displayed in the office and even though they do not contain any private health information, other than patient name, they may be seen by others who are seeking care or services in the office.

FICILTY SET UP

While our examination and treatment rooms are private, this office utilizes an open exercise/rehabilitation setting. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosures to others in the facility at the same time. If there is private information that you need discussed please request to have such discussions in a private room.

YOUR RIGHTS

- Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that your believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or hospitals.

- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.
- You have the right to inspect and have a copy of your health information. There is no cost for the first copy; any other copy thereafter will be \$25.00.
- You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement you will be provided with information about our denial of your amendment and how you may appeal the denial of amendment.
- You have the right to a copy of this notice upon request.

COMPLIANTS

Complaints about your privacy rights or how your privacy is handled at this office can be directed to Martin Griffin by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Ave. S.W.
Room 509F HHH Building
Washington, D.C. 20201

I have read this Privacy Notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above.

Patient Name (printed)

Patient's Signature

Signature of Legal Representative
(e.g., Guardian, Parent if a minor):

Relationship

Date Signed ____/____/____

Witness: _____