NOTICE OF PRIVACY PRACTICES

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

PROTECTING YOUR PRIVACY: Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper, verbally, or on the internet. Your security is one of our highest priorities.

KEEPING YOUR INFORMATION: One of our most important responsibilities is to keep your medical and health information secure. We value your trust and will handle your information with care. Our staff accesses your information only when necessary to provide treatment, verify eligibility, obtain authorization, process claims, and otherwise meet your needs. We may also access information about you when considering a request from you, or when exercising our rights under the law of any agreement with you. Our employees are trained to understand and comply with these information principles.

MAINTAINING ACCURACY: Keeping your health information accurate and current is very important. If you believe the health information we have about you is incomplete, inaccurate, or not current, please contact us immediately.

HOW AND WHY INFORMATION IS SHARED: We limit the types and recipients of your shared information to the following:

- *SHARING INFORMATION WITHIN THE PRACTICE*: We share information within our company to deliver you the healthcare services and the related information within our company to deliver you the healthcare services and the related information and educational programs specified in your plan.
- *SHARING INFORMATION WITH OTHER COMPANIES*: Some of these companies may include, but are not limited to claims processors, transportation providers, diagnostic facilities, etc…These companies act on our behalf and are obliged contractually to keep the information that we have provided them confidential.
- *SUBPOENA, OR ANY LEGAL PROCESS*: Except as required by law, we do not share information with other parties, including government agencies.
- *OTHER*: Patient specific, personally identifiable data is released only when required to provide a service to you and only to those with a need to know, or with your specific consent. Data is released with the condition and understanding that the person receiving the data will not release it further, unless you give them permission.

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of health services, Chiropractic Healthcare Center's staff will create and maintain health records and other information describing, among other things, my clinical history, symptoms, examination results, diagnosis, treatment, x-ray reports/films and any plans for further care and treatment.

I have been provided a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to view the notice prior to signing consent. I understand that Chiropractic Healthcare Center has the right to change this notice and prior to implementation will mail a copy of the revision to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used, or disclosed to carry out treatment, payment, or healthcare operations. Some of these healthcare operations may include, but are not limited to quality assessments, improvement activities, functional capacity evaluations/physical performance evaluations, underwriting premium. I further acknowledge and understand that Chiropractic Healthcare Center is not required to agree to my proposed restriction(s).

By signing this form I give my consent to the use and disclosure of protected health information about me for the purposes of treatment, healthcare operations, and payment. I acknowledge that I also have the right to revoke this consent in writing.

This consent is given with the understanding that:

1. Any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, healthcare operations, and to obtain payment without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my protected health information, which is used, or disclosed for the above stated purposes be restricted. I also understand that Chiropractic Healthcare Center and I must agree on any restrictions in writing that I request on the use and disclosure of my protected health information and agree to terminate any restrictions in writing to the use and disclosure of my protected health information which have been previously agreed upon.

_____ _____ _____

Print Name Social Security # DOB

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Patient Signature/Parent, or Legal Guardian, if under 18 Date