Warren Chiropractic

Notice Of Privacy – HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU HAVE ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

As your health care provider, we are required, by law, to maintain the privacy and confidentiality of your protected health information and provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure Of Your Health Care Purposes
We may disclose your health care information to staff and other healthcare professionals within our practice for the purpose of consultation, treatment, payment, or healthcare operations. Additionally, we disclose your health information to your insurance provider(s), billing and insurance personnel, or medical billing clearinghouse or collection agencies for the purpose of payment for your health care services.

Workers' compensation
We may disclose you health information as necessary to comply with state Work Comp Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or on the event of an emergency.

Other : As required by law, we may disclose your health information to the fallowing persons or entities: -Public Health Authorities, -Law Enforcements Officials, -Medical Examiners or Coroners, -Specialized Government Agencies

Communications
We may contact you for additional communications, or other purpose, as described below *Birthday cards and/or seasonal greeting cards may be sent to your home periodically throughout the year, which may offer you a discounted or free service, a gift, or medical reminders. If this is not desired, please tell our personnel so alternative methods might be utilized to protect your privacy. When you are being seen in the office, other patients may hear and see the care you receive. A private area is available upon request.*

Change of Ownership
In the event that this practice is sold of merged with another organization, your health record will become the property of the new owner.

Your health Information Rights -You have the right to request restrictions on certain uses and disclosers of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested. -You have the right to inspect and copy your health information. -You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If you requested to amend your health information has been denied, you will be provided with a explanation of our denial reason(s) and information about how you can disagree with the denial. -You have a right to receive an accounting of disclosures of your protected health information made by our office. -You have a right to paper copy of this Notice of Privacy Practices at any time upon request.

Changes to This Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. We are required by law to maintain the privacy of your health information and provide you with notice of our legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about our privacy rights, please contact Warren Chiropractic personnel.

Complaints
Complaints about our Privacy Rights or how our office handles the use or disclosure of your health information should be directed to our office personnel. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DDHS, Office of Civil Rights, 200 Independence Ave., S.W., Room 509F HHH Building, Washington, DC 20201

I have read the privacy notice and understand my rights contained in the notice.

Printed Name of Patient: _____

Signature of Patient: _____ Date: ___/___/___

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