

NOTICE OF PRIVACY PRACTICES

1. Understanding Your Health Record/Information

Each time you visit a hospital, physician, acupuncturist, chiropractor, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided
- a tool for educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

2. Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of this Notice of Privacy Practices upon request
- inspect and obtain a copy of your health record
- amend your health record under certain circumstances
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

3. Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practice change, we will mail a revised notice to the address you supply to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

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4. For more information or to Report a Problem

Patient name: _____

Address: _____

Date of birth: _____

Health information to be disclosed: _____

Individual(s), entities or business associates to receive this health information: _____

Specific purpose of this disclosure: _____

Effective dates of this authorization: ____/____/____ through ____/____/____

(The authorization will expire at the end of this period.)

I hereby authorize this office to disclose my health information as described in this document.

Signature of Patient (or authorized representative)

Date