

# RAY CHIROPRACTIC

## NOTICE OF PRIVACY PRACTICES

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.

**RAY CHIROPRACTIC** is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Uses and Disclosures of Your Health Care information**

Your protected health information may be used and disclosed by your physician, our staff, or others, that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your health care bill, to support the operation of the physicians practice, and any other use required by law.

### **Treatment**

We may disclose your health care information to provide, coordinate or manage your health care and many related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your health information, as necessary, to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

### **Payment**

We may disclose your health information to an insurance company for the purpose of payment or health care operations.

### **Health Care Operations**

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health authorities, communicable diseases, health oversight, abuse and neglect, Food and Drug Administrations, legal proceedings, law enforcement, coroners, funeral directors, organ donations, research, criminal activity, military activity and national security, workers compensation, inmates, public safety, emergencies, required uses and disclosures. Under law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

### **Change of Ownership**

In the event that RAY CHIROPRACTIC is sold or merged with another organization, your health information/records will become the property of the new owner.

**Your Health Information Rights**

- You have the right to request restrictions on certain used and disclosures of your health information.
- You have the right to have your health information received or communicated through an alternative method other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that RAY CHIROPRACTIC amend your protected health information. Please be advised, however, that RAY CHIROPRACTIC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reasons and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by RAY CHIROPRACTIC.
- You have a right to a paper copy of the Notice of Privacy Practices at any time upon request.
- You have a right to file a complaint to us or the Secretary of Health Human Services if you believe that your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint.

**Changes to this Notice of Privacy Practices**

RAY CHIROPRACTIC reserves 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. Until such amendment is made RAY CHIROPRACTIC is required by law to comply with this notice.

This Notice is effective as of April 1, 2003.

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

By way of my signature, I provide RAY CHIROPRACTIC with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment, and health care operation as described in the Privacy Notice.

\_\_\_\_\_  
Patients Name (print)

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

## Authorization to Use or Disclose Protected Health Information RAY CHIROPRACTIC

Patients Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Request: \_\_\_\_\_

As required by the Privacy Regulations, **RAY CHIROPRACTIC** may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s) or business associates outside of this office:

- Any insurance carrier, attorney, or adjuster for the purpose of reimbursement of charges.
- Any outside referrals, adjuster, employer, case manager, or attorney for the purpose or treatment, diagnosis, coordination of care, or any other party we deem necessary as it is related to your condition.
- Other: \_\_\_\_\_

Patient Health Information authorized to be disclosed:

- Demographics
- Lab Results
- X-Rays
- Outside Medical Records
- History and Physical
- Complete Health Records
- Narrative Reports
- Other \_\_\_\_\_

This Authorization is effective from the time treatment is received with no expiration unless rescinded in writing. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this offices previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to marketing activity as allowed by this authorization as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Signature of Facility

\_\_\_\_\_  
Date