Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how chiropractic and medical information about you may be used and disclosed and how you obtain access to this information. Please review it carefully.

In the course of your care as a patient at Foundation Chiropractic Center, we may use or disclose personal and health information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if necessary to refer you for further diagnosis or care.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or employer if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have the right to request restrictions in your use of protected health information for care, payment, or operations purposes. Such requests are not automatic and request the agreement of this office.

If you are not home to receive an appointment reminder or other information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or alternative agreement of this office.

We are permitted and may be required to use or disclose information without your authorization in these following circumstances:

- If we provide healthcare services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide you care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any disclosures made by this office.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by persons to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also inform you regarding your health care or about the state of your account. If you receive this information at an address other than your home, or if you would like the information in a specific form, please advise us in writing as to your preference.

We are required by state and federal law to maintain the privacy of your patient file and the health information herein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are also required to follow the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will not be a disadvantage to you.

If you have a complaint regarding our privacy practices or any aspect of our privacy activities, you should direct your complaint to our front desk staff. We will do our best to resolve the privacy issue in the office as soon as possible. If your issue does not get resolved, please contact the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with our office or with the Secretary, your care will continue and this office and our staff will not disadvantage you.

This notice is effective as of October 28, 2019 and any alterations or amendments made here will expire seven years after the date upon which the record was created. Your signature acknowledges that you have read and understand this notice and may be given a copy if so requested.

____

Name (print) Signature Date

____

Representative of Minor (print) Signature Date

Foundation Chiropractic Center
Medical Information Release Form
(HIPAA Release Form)

Name: ____________________ Date of Birth:______________

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ______________

[ ] Child(ren) ____________________________

[ ] Other: _______________

[ ] Information is NOT to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages (please call):

[ ] my home

[ ] my work

[ ] my mobile number:

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call:

[ ] The best time to reach me is (day) ________between (time) ______________AM / PM

Signed: ______________________ Date:___________________