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RESTORATION CHIROPRACTIC

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation (PHI). In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition we have several copies in folders labeled 'HIPAA' behind the reception desk. Once you have read this notice please sign the last page and return only the signature page (page 2) to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from any insurance company or other available collateral source, OR
4. To obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/doctor.
5. For workers compensation purposes- to process a claim or aid in investigation
6. Emergency- in the event of a medical emergency we may notify a family member
7. For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
8. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
9. For military, national security, prisoner and government benefits purposes.
10. Deceased persons –discussion with coroners and medical examiners in the event of a patients death
11. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or inform you of changes in practice hours or up coming events.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI

Note: At any time this office may update the list of ways your Private Health Information may be used and this notice will become retroactive.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Nancy at 815-744-2244. If Nancy) is unavailable, you may make an appointment with our staff to see her within 2 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

[1]REGARDING NOTICE OF YOUR RIGHT TO PRIVACY continued from page 1 ….

Patient initials __________.

I **understand that this** office reserves the right to amend this notice of privacy practice at a time in the future and will make the new provisions effective for all information that it maintains past and present. My signature below is an acknowledgement that I have received a copy of Restoration Chiropractic Patient Privacy Notice and I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I acknowledge that a more comprehensive version of this "Notice" is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____ _______________

Patient signature Date

____ _______________

Witness Date

____ _______________

Print Witness Name Date

Office copy