Lancaster Chiropractic

HIPPA 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.

Treatment: We may use your health information to provide you with our professional services. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. Health information about you may also be disclosed to those other persons you choose to involve in your care (see Message Consent form).

Payment: We may use and disclose your health information to seek payment for services we provide to you. This involves our office staff and/or insurance companies or other businesses that may be involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify or assist in notifying your family or anyone else responsible for your care, in case of an emergency. If you are incapacitated, we will use our professional judgment to only share your health information with those you have designated.

Law: We may use or disclose your health information as required by law including, but not limited to: court or administrative orders, subpoenas, and discovery requests.

Abuse/Neglect: We may disclose your health information to appropriate authorities if we believe you are a possible victim of abuse, neglect, or other crimes.

Public Health Responsibilities: We will disclose your health care information to report problems with or reactions to products, infection or disease exposure, injury, or disability.

National Security: The health information of military personnel may be disclosed to federal officials under certain circumstances if the information is required for lawful reasons.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders via voicemail messages or other correspondence.

In order to protect your privacy, we will **NOT** leave messages concerning your health info with anyone but you or your legal guardian, or leave your health information on an answering machine or in a voice mail box **UNLESS** you give written permission for us to leave messages for you as listed below:

HOME PHONE ☐ Yes ☐ No OTHER _____

OFFICE PHONE ☐ Yes ☐ No _____

CELL PHONE ☐ Yes ☐ No

SPOUSE OR OTHER HOUSEHOLD MEMBERS: ☐ Yes ☐ No

This authorization will remain in effect until otherwise notified in writing.

Access: Upon written request, you have the right to review or obtain copies of your health information. There may be a charge for copies or postage if these copies are mailed to you.

Non-routine Disclosures: You have the right to a list of occurrences in which we disclosed your information for reasons other than routine reasons, treatment, payment, or healthcare operations.

Restrictions: You have the right to request that we place restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by the agreement, except in emergency situations. Any restriction requests must be submitted in writing.

Questions: You have the right to file a complaint with us if you feel we have not complied with these privacy practices. If you choose to file a formal complaint with us or with the US Department of Health and Human Services, we will not retaliate in any way.

Please list all people, and their relationship to you, we may discuss your care and other information with:

_____

_____

_____

_____

_____

_____ _____

Patient Signature (or Guardian Signature) Date

_____ _____

PRINTED Name (First/Last) Date of Birth