



1155 Kildaire Farm Rd, Ste 101, Cary, NC 27511

## **Privacy Practices for Protected Health Information**

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

### **Use and Disclosures**

Here are some examples of how this office might have to disclose or use your health information:

1. Your chiropractor or staff member may have to disclose your health information, including all of your clinical records to another health care provider or hospital if necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, HMO, PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your chiropractor and members of staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine. You have a right to confidential communications and to request restrictions relative to such contacts. You also have a right to be contacted by alternative means or at alternative locations.
4. Your chiropractor or staff may need to use your name, address, and phone number in order to send you informational newsletters, birthday cards or thank you cards.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to or the methods we use to obtain reimbursement for your care.

### **Permitted Disclosures**

Under Federal Law, we are also permitted or required to use or disclose your health information in the following circumstances:

1. We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
3. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
4. We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding four examples, any other use or disclosure of your health information will be made with your written authorization.

### **Your Rights Concerning Your Health Information**

1. You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request.
  - a) If we have already released your health information before we receive your request to revoke your authorization.

- b) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at Chiropractic Wellness Center of Cary, PLLC, 1155 Kildaire Farm Rd, Ste 101, Cary, NC 27511.
2. If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another provider.
  3. We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home, or if you would like the information in a different form. To help us respond to your needs, please make the request in writing.
  4. You have the right to inspect and/or copy your health information for seven years from the date that the record was created. We require your request in writing to inspect and/or copy your health information.
  5. You have the right to request that we amend your health information for seven years from the date that the record was created. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.
  6. You have the right to request that we give you an accounting of the disclosures that we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except those required for your treatment, to obtain payment for your services, or to run our practice. We will provide the first accounting within any 12 month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request, we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.
  7. You have a right to obtain a paper copy of this notice.
  8. You have the right to complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint, and will not take any action against you if you file a complaint. You make an oral complaint at any time. Written complaints should be addressed to the Secretary of the Department of Human Services.

### Our Duties

1. We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with your request to your health information.
2. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all of your health information.
3. Information that we use or disclose on the authorization you are giving us may be subject to a re-disclosure by the person to whom we provide the information and may no longer be protected by the Federal privacy rules.

This notice is effective as of \_\_\_\_\_. This notice will expire seven years after the date upon this record was created. By signing below, I acknowledge that I have received a copy of this notice.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date