## PRIVACY STATEMENT FOR PATIENTS

Welcome to our practice. In accordance with the Health Insurance Portability and Accountability Act of 1996, our practice is publishing our privacy and security policies for your reference. Your personal information is protected here at Whole Healing Chiropractic and Acupuncture, LLC. Under the law, your protected personal health information may be released to designated health plans or other health care providers without specific authorization in accordance with the law to treat you, obtain payment and conduct normal practice operations. This is called a CONSENT form. We will ask you to sign our consent form for treatment here at Whole Healing Chiropractic and Acupuncture, LLC. This consent is valid for all treatment and related operational activity. If you wish to release your protected health information for any other purpose, such as a disability, a life insurance company or a physician not associated with your treatment, you will need to sign a specific authorization.

## OUR PRIVACY POLICY

1. Whole Healing Chiropractic and Acupuncture, LLC will take all reasonable steps that the minimum necessary amount of information is disclosed to accomplish practice operations, obtain payment for your services and render treatment to you. Such operations include the sending of claims and records to obtain payments, the dictation, typing and filing of medical office notes. Discussion with insurance companies to obtain payment, discussion with collection agencies, i.e., radiologists, laboratories, and other physicians.

2. Your entire medical record will never be released to anyone, unless specifically authorized by you, in writing. You have a right to restrict to whom you allow a portion, or all of your record released to. Your records, may, however be released without an authorization in the course of legal investigations by state or federal agencies. Should you need to restrict to whom your records are released, please call or see the Director of Operations.

3. You have a right to inspect your medical records, with reasonable notice to the Director of Operations. You will then be allowed to inspect the records, with the Director present. You have a right to ask that your medical records be amended, however, that is only a request, and the physician is not obligated to comply. You may address a request to the treating physician. Your request will be evaluated, and a written response sent to you. The request and reply will be kept in your medical record. If you disagree with the decision of the treating physician, you may request that the President of the Practice evaluate the request. His reply shall be sent to you in writing.

4. If you choose to receive a copy of your medical records, the cost of this will be quoted.

5. We keep a list of all medical record releases here at the practice. You have a right to inspect to whom and when your personal health information is sent to.

6. Our staff and physicians are trained in the policies and procedures concerning the release of protected health information. Each of our staff has signed a Confidentiality Agreement here at Whole Healing Chiropractic and Acupuncture, LLC.

7. All complaints regarding the safeguarding of your personal protected health information can be directed to the Director of Operations. You will receive a written reply to any concerns.

8. If there are any changes to this policy statement, it will be posted in our office

## PATIENT CONSENT FOR TREATMENT AND RELEASE OF PERSONAL INFORMATION

I have been given a copy of the privacy policy and consent to treatment at Whole Healing Chiropractic and Acupuncture, LLC. I understand that information about me may be used or disclosed in, the context of normal practice operations, including all treatment, filing of claims, and the receiving of payments for services provided. I understand that information for any other purpose may not be released to anyone without my specific authorization. I may revoke this consent at any time, but it will not have any effect on any actions taken prior to my revoking the consent.

Patient Name _____ Date _____
*Please Print*

Patient Signature _____

**If patient unable to sign:**

Patient Representative _____ Date _____
*Please Print*

Patient Representative Signature _____

Relation to Patient _____

**I have no objection to the physician discussing my medical or surgical care and treatment with the following persons.**

Name: _____ Relationship: _____ Phone: _____
*(Please Print)*

Name: _____ Relationship: _____ Phone: _____
*(Please Print)*

Name: _____ Relationship: _____ Phone: _____
*(Please Print)*