Rose Chiropractic Clinic

Notice of Privacy Practices

This Notice describes how your medical information you have given to us may be used and disclosed, and how you can get access to this information. Please review it carefully.

How We May Use and Disclose Medical Information About You.

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Some examples are provided. Not all possible uses or disclosures are listed.

For Treatment or Health Care : We may use medical information about you to provide you with medical treatment or services and to assure that you receive quality care. Example: We may use this information to recommend alternative treatment, to review our treatment and services, and evaluate the performance of our staff in caring for you.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed, and payment may be collected for you from an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, birthdate, age, personal insurance numbers, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization:

* As required by law enforcement.
* To avert a serious threat to others' personal safety.
* Uses and disclosures in domestic violence or neglect situations.
* Uses and disclosures required by law.
* Disaster Relief.
* Specialized Government Function for National Security & Intelligence Activities.
* Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.
* Health Oversight Activities authorized by law, including audits.

Unless you notify us in writing, your name, location, general condition, or death may be disclosed according to the above list. If you are present, we will get your permission if possible, and give you the opportunity to refuse permission. In case of emergency or to clergy, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best

interest about allowing someone to pick up medical supplies, vitamins, x-ray or medical information for you.

Your personal information will never be disclosed for fundraising purposes.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization: Other uses and disclosures of medical information required to be sent or given to other healthcare providers, lawyers (unless we receive a subpoena, administrative order, discovery request, or other lawful process, under certain circumstances), other insurance companies other than your own, other family members (unless in circumstances listed in the above disclosure statement). All will require your signature on a release form, authorizing your personal information be given, before the information will be disclosed to them.

Personal information of a child which is of legal age will not be disclosed to a parent or family member without the signature of the legal age person authorizing the release of the information (unless circumstances apply in the above disclosure statement) .

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us authoriaztion to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided for you.

Your Individual Rights: You have the right to:

1. Receive a list of all the times we shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
2. Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information, and you may request a review of the denial. Requests must be made in writing. Contact our Privacy Officer for appropriate form.
3. Request that we place additional restrictions on our use or disclosures of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means, or to different locations. Your request must be made in writing to the contact person here at our office listed at the end of this notice.
5. Request that we change your medical information. This request must be made in

writing. We may deny your request if we did not create the information you want changed, or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to

change the information, we will make reasonable efforts to tell others, including people you name, of the change, and to include the changes in any future sharing of that information.

Questions and Complaints:

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact our Privacy Officer. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services.
All complaints must be submitted in writing.

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g., a billing service), sites and locations of this practice may share medical information with each other
for treatment, payment purposes, or health care operations explained in this notice.

Rose Chiropractic Clinic

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Protecting your health information is important. We maintain the confidentiality of your personal information.

Notice of Privacy Practices Patient Acknowledgement

Patient Name:_________________________________
(please print)
Date of Birth:_________________________________

I have received the Notice of Privacy Practices written in plain language of the office of Dr. Thomas D. Rose, D.C. The notice provides detailed information about the uses and disclosures of my protected health information that may be made by this practice of my individual rights, and how I may exercise them, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practice and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:__________________________________ Date:____________________

Relationship to patient (if signed by a personal representative of patient):______________

Person to contact on our Privacy Practices: Cyndee Rose - 896-8820

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