Kimberton Chiropractic

HIPAA Form

Notice of Privacy Practices

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy policies.

Use and Disclosure of Health Information

Treatment: We may use or disclose your health information to a physician or other healthcare provider.

Payment: We may use or disclose your health information to obtain payment for services rendered to you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give written authorization to disclose your health information to your family member, friend, or other person to the extent necessary to help with your healthcare.

Authorized Name:_____
Phone: _____
Relationship:_____

Required by Law: We may use or disclose your health information when required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, domestic violence, or other crime. We may also disclose your health information to the extent necessary to avert a serious threat to your health and safety or the health and safety of others.

Patient's Rights

You have the right to review or get copies of your health information with limited exception. You must make a written request to obtain access to your health information. There is a charge for copied records, treatment summaries or other written reports.

Questions or Complaints

If you have a concern or complaint about our privacy practices please speak to us directly and we will make every effort to clarify or resolve the situation.

If you are concerned we may have violated your privacy rights or you disagree with a decision we have made about access to your health information and we are able to resolve the situation you may submit a written complaint to the U.S. Department of Health and Human Services.

Acknowledgement of Privacy Notice

I acknowledge receiving Kimberton Chiropractic's Notice of Privacy Policy

_____ _____

Patient or Responsible Party Signature Date

I hereby authorize Kimberton Chiropractic to (please circle):

YES/NO –use my photo in office materials such as success story, scrap book, website

YES/NO –use my name for marketing purposes such as a success story, website, or conjunction with events and stories