

# PRIVACY NOTICE

## Consent for Use of Disclosure of Health Information

We are concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose you health care information:

1. We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes.

We reserve the right to change our privacy practices as described in this notice. If we make changes to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

## Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree with your restrictions. However, if we agree to your restrictions, the restriction is binding on us.

## Your Right to Revoke Your Authorization

You may revoke any of your authorizations at any time, however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. 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.

## Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing the consent form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

Information that we use or disclose based on the authorization you are giving us, may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not effect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time.

## Tennessee Chiropractic Association Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Tennessee Chiropractic Association (TCA). This disclosure will be made if we need the TCA's assistance to receive reimbursement for your services or, we need the TCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing the consent form, you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf. You may inspect or copy the information that we may send to the TCA at any time.

Effective Date: This notice is effective as of January 1, 2015 and authorization will expire seven years after the date on which you last received services from us.

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I have read your Privacy Notice and agree to its terms. I authorize you to use or disclose my health information in the manner described in the Privacy Notice.

Print Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Representative \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Office Representative \_\_\_\_\_ Date \_\_\_\_\_